CATALOGUE OF
STATE MEDICAID PROGRAM CHANGES
Spring 1982 Update

State Medicaid
Information Center

Center for Policy Research
National Governors' Association

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Spring 1982 Update

May 1982

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444 North Capitol Street
Washington, D.C. 20001
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The development and production of this publication was supervised by Lawrence Bartlett of Bartlett Associates, Washington, D.C., who is the Project Coordinator of the State Medicaid Information Center. Claudia Hanson and Irene Zarechnak labored diligently to collect within a short period of time the bulk of the information presented here. Thanks are due to Dotty Esher and Linda Butler, who arranged the information collected in what is hoped to be a useful format, and to Richard Curtis and Joan Wills of NGA and Anthony Parker, HCFA Project Officer, for their support of the project. We would also like to express our appreciation to the Intergovernmental Health Policy Project of the George Washington University for the information it shared with us on state legislative activity.

Most importantly, however, thanks are due the state Medicaid directors and their staffs for their patience in responding to our constant queries and requests for verification. We are hopeful that the program planning and administration data in this document will provide adequate compensation for their efforts and ensure their future cooperation.

INTRODUCTION

Spiraling health care costs, the economic downturn, and the recently legislated reductions in federal funds have pushed strained state budgets to the breaking point. As a result, state officials must restrain expenditures in their Medicaid programs – which represent the largest and most rapidly escalating components of most state budgets. Such a task is complicated further by the need for officials to strive to minimize the adverse impact of any action on the provision of health care to those in need. In order to make the best possible choices among various alternatives, it is imperative that these decision-makers have at their disposal complete and up-to-date information on potential cost containment approaches. Certainly an important resource for officials in a given state would be information concerning the experience other states have had in controlling expenditures in their Medicaid programs.

To address this critical information need, the National Governors' Association's Center for Policy Research, through a grant awarded by the Health Care Financing Administration, has established the State Medicaid Information Center (SMIC). The purpose of the SMIC project is to serve as a central source of information concerning cost containment strategies adopted by individual state Medicaid programs.

A Catalogue of State Medicaid Program Changes: Spring 1982 Update is intended to be supplement to an earlier SMIC publication, A Catalogue of State Medicaid Program Changes, issued in September 1981. The purposes of these two documents are the same: namely, to serve as a complete and easy-to-use reference document containing summaries of individual states' Medicaid cost containment activities. These guides were meant to provide state officials with ready access to abstracts of the experience of other states which have pursued specific policy initiatives and to expand the range of potential policy alternatives available for consideration by a state. Prior to the publication of the Catalogue, no central source of such information existed.

Over 1700 abstracts contained in the Catalogue reflect program changes which were initiated by individual states and which were implemented during the period from July 1978 through July 1981. More than 1,000 entries are included in this first Update, the bulk of which describe program changes implemented or proposed during the latter half of 1981 or the first part of 1982.

As with the Catalogue, both primary and secondary sources of data on state cost containment activities have been consulted in the preparation of the Update, and every effort has been made to verify all information directly with each state agency. In order to provide as full and complete a data base as possible, information on state-initiated changes which have expanded the scope of their programs also is presented in this document, as are some of the more significant changes which recently have been proposed but as yet have not been implemented. Program modifications required of all states, as the result of changes in federal requirements (e.g., mandatory coverage of rural health clinics), have not been included. The estimated dollar impact of particular program changes is presented when states have provided this information.

We have received a very strong, positive response to the publication of A Catalogue of State Medicaid Program Changes. It is hoped that the information presented in this Update will prove useful to state officials in their efforts to control escalating Medicaid expenditures while maintaining access to needed health services for the nation's poor.

May 1982

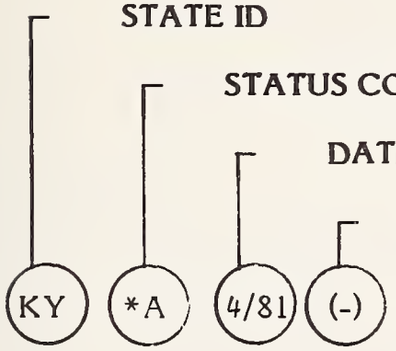
HOW TO USE THIS DOCUMENT

Included in this Update are data on individual state Medicaid program changes which were reported to SMIC staff after the publication of the Catalogue in the fall of 1981. Most of the information describes program changes made or proposed during the latter half of 1981 or the first part of 1982. Abstracts of these changes are included within one or more of the six major sections of this Update, which are as follows:

I. Benefit Packages
II. Utilization Controls
III. Reimbursement
IV. Administration and Management
V. Eligibility
VI. Alternative Methods of Service Delivery/Program Management

Within Sections I, II, and III are listed changes made in the amount, duration, and scope of services; utilization controls; and reimbursement practices, respectively. Changes of a broad nature affecting a number of different services are listed under a "General" heading in these sections; changes affecting a particular service are listed under a "Specific Services" heading by individual service. Sections IV, V, and VI also are divided into a number of subsections. A complete outline of the sections containing program abstracts, as well as lists of all services which are identified in Sections I through III and the state abbreviations used herein, are presented at the end of the this section.

In order to explain the general format for all Update entries, a sample of an abstract of a state program change is presented as follows:



The program will reimburse only for tests specifically ordered by a physician rather than the current practice of reimbursing for a standard battery of tests provided to all patients on admission.

The **STATE ID** is a two-character code which identifies the state in which the program change was implemented or proposed. A listing of these codes is presented at the end of this section.

The **STATUS CODE** indicates the latest reported status of a particular program change. The Codes are:

*A Change adopted or implemented by state
*C Program change being considered by state
*D Change in effect on a demonstration basis
*P Program change formally proposed by a state agency, pending a final decision

The **DATE CODE** indicates the year and, when possible, the month in which a particular change first was proposed or implemented.

The **IMPACT CODE** indicates whether the change resulted or is expected to result in an increase (+) or decrease (-) in program expenditures.

The **DESCRIPTION** is a brief statement of the program change. Additional information, such as the estimated dollar impact, is included when available.

Within each subsection, abstracts are listed alphabetically by state. Where there is more than one abstract for a given state, the listings are arranged in chronological order beginning with the most recent change.

In addition to the six major portions which contain abstracts of state program changes, included in the Update is a section on **Selected State Medicaid Program Characteristics,** which contains tables summarizing certain current aspects of all state Medicaid programs, regardless of the date these policies and procedures first were implemented.

OUTLINE OF CATALOGUE UPDATE

I. Benefit Packages
   - A. General
   - B. Specific Services
     (See attached list of services)

II. Utilization Controls
   - A. General
   - B. Specific Services
     (See attached list of services)

III. Reimbursement
   - A. General
   - B. Specific Services
     (See attached list of services)

IV. Administration and Management
   - A. Reducing Eligibility Errors
   - B. Maximizing Payments from Other Sources
   - C. Fraud and Abuse
   - D. Claims Processing
   - E. Purchase of Service
   - F. Other

V. Eligibility
   - A. Coverage of Optional Groups
   - B. Income Levels
   - C. Resource Standards/Rules
   - D. Definitions
   - E. Other

VI. Alternative Methods of Service Delivery/Program Management
   - A. Capitation
   - B. Long-Term Care Delivery
   - C. Other

LIST OF SERVICES

1. Inpatient Hospital Services
2. Outpatient Hospital Services
3. Rural Health Clinic Services
4. Laboratory and X-Ray
5. Skilled Nursing Facility (SNF) for Individuals 21 and older
6. Home Health Services
7. Physician Services
8. Early and Periodic Screening Diagnosis and Treatment
9. Family Planning
10. Intermediate Care Facility (ICF)
11. Intermediate Care Facility Services for the Mentally Retarded
12. Inpatient Psychiatric Services for Individuals under 22
13. Inpatient Hospital Services for those 65 + in an Institution for Mental Disease (IMD)
14. SNF Services for those 65 + in an IMD
15. ICF Services for those 65 + in an IMD
16. SNF Services for those under 21
17. Inpatient Hospital Services for those 65 + in a TB Institution
18. SNF Services for those 65 + in a TB Institution
19. ICF Services for those 65 + in a TB Institution
20. Personal Care Services
21. Emergency Hospital Services
22. Prescribed Drugs
23. Dental Services
24. Dentures
25. Clinic Services
26. Eyeglasses
27. Optometrists' Services
28. Diagnostic Services
29. Screening Services
30. Preventive Services
31. Rehabilitative Services
32. Podiatrists' Services
33. Chiropractors' Services
34. Other Practitioners

LIST OF SERVICES
(continued)

35. Private Duty Nurse
36. Physical Therapy
37. Occupational Therapy
38. Speech, Hearing, and Language Disorders
39. Prosthetic Devices
40. Christian Science Nurses
41. Christian Science Sanitoria
42. Durable Medical Equipment and Supplies
43. Transportation

STATE ABBREVIATIONS

Alabama	AL	Nebraska	NE
Alaska	AK	Nevada	NV
Arizona	AZ	New Hampshire	NH
Arkansas	AR	New Jersey	NJ
California	CA	New Mexico	NM
Colorado	CO	New York	NY
Connecticut	CT	North Carolina	NC
Delaware	DE	North Dakota	ND
District of Columbia	DC	Northern Marianas	TT
Florida	FL	Ohio	OH
Georgia	GA	Oklahoma	OK
Guam	GU	Oregon	OR
Hawaii	HI	Pennsylvania	PA
Idaho	ID	Puerto Rico	PR
Illinois	IL	Rhode Island	RI
Indiana	IN	South Carolina	SC
Iowa	IA	South Dakota	SD
Kansas	KS	Tennessee	TN
Kentucky	KY	Texas	TX
Louisiana	LA	Utah	UT
Maine	ME	Vermont	VT
Maryland	MD	Virgin Islands	VI
Massachusetts	MA	Virginia	VA
Michigan	MI	Washington	WA
Minnesota	MN	West Virginia	WV
Mississippi	MS	Wisconsin	WI
Missouri	MO	Wyoming	WY
Montana	MT		

Selected State Medicaid Program Characteristics

SELECTED STATE MEDICAID PROGRAM CHARACTERISTICS

Contents

SELECTED STATE MEDICAID PROGRAM CHARACTERISTICS
Spring, 1982

I. ADMINISTRATIVE METHODS

	AL	AK	AZ	AR	CA	CO	CT	DE	DC	FL	GA	GU	HI	ID	IL	IN	IA	KS	KY	LA	ME	MD	MA	MI	MN	MS	MO	MT	NE	NV	NH	NJ	NM	NY	NC	ND	OH	OK	OR	PA	PR	RI	SC	SD	TN	TX	TT	UT	VT	VI	VA	WA	WV	WI	WY	Total y+c+d
A. To Reduce Eligibility Errors																																																									
1. Error prone profiling	y			y	y	n	n	y	n	n	n	n	y	n		n	p	n	p	n	n	n	y	p	n	y		p	n	n	p	n	n	n	n	n	p	n	n	n		c	n	p	n		n	n		n	p	y	p	n	9
2. Consalidation of welfare and Medicaid eligibility applications		y		y	y	y	y	c	y	y	y	y	y	y	y	p		y	y	y	c	p	p	y	y	c	y	y	y		y	y	y	y	y	p	y	y	y		y	y	n	y	y		p	y		y	y	y	y	y	42
3. Manthly issuance or retrieval of Medicald ID cards	y	y		y	y	y	y	c	y	y	y	y	y	y	y	p	y	y	y	y	y	y	y	y	y	y	y	y	y		y	c	y	y	y	n	y	y	y	n		y	y		y	y	y	y	y	47
4. Training eligibility determinatian workers	y	y		y	y	y	y	y	p	y	y	p	y	y	y	y	p	y	y	y	y	y	y	y	y	y	y	y	y		y	y	y	y	y	y	y	y	y		y	y		y	y	y	y	y	49
5. Manitoring eligibility determinatian workers' perfarmances	y	y		y	c	y	y	y	p	y	y	y	y	y	y	y		y	y	y	y	p	y	y	y	y	y	y	y		y	n	y	y	y	y	y	y	y		y	y		y	y	y	p	y	47
6. Manitoring of client incame thraugh linkages with other employment data files	y	p		y	d	y	y	y	n	y	y	n		y	y	y	y	y	y	y	c	y	y	p	n	y	y	p	p	y	y	c	y	y	y	n	y	y	y		n	y	y	n	y	y		y	y	y	y	n	40
7. Monthly ar quarterly status reparts submitted by recipients	y	n		n	c	c	n	y	y	n	n	n	y	y		n	p	c	p	n	n	c	y	c	y	y	y	n	y		n	y	n	n	p	y	n	c	p	y	y	n	n		n	y		n	y	n	n		n	y		p	y	y	c	n	25
8. Provider verificatian of client identificatian	p	y		y	n	n	y	y	p	n	n	n	y	n	y	y	y	y	y	y	y	y	y	y	y	y	y	y	n		y	c	y	y	y	n	y	n	y		y	y		n	y	y	y	n		y	n		n	y	y	y	n	37
9. Pravider telephone inquiries to state re patient's eligibility status		y		y	n	y	n	y	y	y	y	y	y	y	p	n	y	n	n	y	n	p		y	y	y	y	y	y		y	n	y	y	y	y	n	y	y	y		y	y		y	y	y	y	y		y	y		n	y	n	y	n	38
10. Personal pickup of checks		c		n	n	n	n	n	n	n	n	n		n	c	n		n	n	n	n	n		n	n	n	n	n			c	n		n	n	n	y	n	y	y	n		n	n		n	n	n	y	n		c	n		n	c	n	n	n	8
11. Photo ID	n	n		n	p	y	p	c	p	n	n	n		n	y	c		d	n	n	n	c	p	n	n	n	n	n			n	c		n	n	n	y	n	n	y	n	y	n		n	n		n	n	n	y	n		n	n		n	n	n	n	n	10
B. To Recover Funds From The Following Sources																																																											
1. Absent parents	d	n		y	c	n	y	y	p	y	y	n		y	y	y	y	y	y	y	y	y	y	y	c	c	y	y	p		y	y	p	y	y	n	y	p	n		y	y		n	y	p	y	y		y	y		p	y	p	y	y	38
2. Veterans Administratian	y	n		n	n	n	y	y	y	y	n	n	y	y		y		n	y	y	n	n	y	p	c	y	y	y	p		y	y	y	n	y	y	y	n	n		y	y		p	y	y	n	n		n	y		y	y	n	n	y	29
3. Health insurance	y	y		y	y	y	y	y	y	y	y	y	y	y	y	y	y	y	y	y	y	y	y	y	y	y	y	y	y		y	y	y	y	y	y	y	y	y		y	y		y	y	y	y	y		y	y		y	y	y	y	y	52
4. Casualty insurance	y	y		y	y	y	y	y	y	y	y	p	y	y	y	y	y	y	y	y	y	y	y	y	y	y	y	y	y		y	y	y	y	y	y	y	y	y		y	y		y	y	y	y	y		y	y		y	y	y	y	y	51

Medicaid program

data not provided

data not provided

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Key: y = Yes; n = No; p = Praposed; d = Demanstratian Basis; c = Certain Pracedures, Services, ar Recipient Categories

SELECTED STATE MEDICAID PROGRAM CHARACTERISTICS
Spring, 1982

II. UTILIZATION CONTROLS

	AL	AK	AZ	AR	CA	CO	CT	DE	DC	FL	GA	GU	HI	ID	IL	IN	IA	KS	KY	LA	ME	MD	MA	MI	MN	MS	MO	MT	NE	NV	NH	NJ	NM	NY	NC	ND	OH	OK	OR	PA	PR	RI	SC	SD	TN	TX	TT	UT	VT	VI	VA	WA	WV	WI	WY	Total y+c+d
A. Prior Authorization																																																								
1. Inpatient hospital	c	n		c	y	n	c	n	c		c	c	p/c	c	c	c	p	c	p	n	n	c		c	c	n	n	n			c	c	n	c	c	c	c	c	c	n	n	c		n	n	c		c	c			p/c	c	c	c	29
2. Nursing home	y	y			y	y	c	y	y	y	y	n		y		y		y	y	y	y	y	y	c	y/d	y	c	n	y			y	y		c	y	y		y	y	n	c	y		n	y	y		y	y			c	y	c		38
3. Home health	y	y			y	y	c	n	n			n			y	y		n	y	n	n	n	c	n	n	y	p	n		y	n	y	y	y	n	n		n	y	n	c	c		n	n	y		c	n			c	y	c		22
4. Physician services	c	n		c	y	n	c	y	y	c	c	y				y	c	c	p	y	c	n	y	c	c	n	c	n			y	c	n	c	c	n	c	n	c	n	c	c	p	n	y	c		c	c			c	c	c	c	34
5. Other services	c	c		c	c	c	c	y	c	c	c	c	p	c		y	y	c	c	y	c	c	c	c	c	n	c	c	c	c	c	c	c	c	y	c	c	c	y		c	n	c	c		c	c		c	c	c	c		46
B. Lock-In Program for High Utilizers	y	p		y	y	y	c	p	p	p	p	n	y	p	y	y	y	y	y	y	c	y	c	y	y	n	y	y	y		n	y	y	y	y	y	p	n	n	y	n	y		n	y	n		y	y		y	y	y	y	y	y	35
C. Limitation on number of hospital days covered				y							y						y					y		c			y				y												y	y										y			11
D. Mandatory second surgical opinion program for certain procedures					p		p								y								y	y			y				y																						y		y		7
E. Monitoring hospital discharge planning units		n		n	n	y	p	y	y	p	n	y		d		y	n	n	n	n	n	y	d	n	n	y	y	n	n	p/d	y	c		y		y		n	y	y	n			n	n	n		n	y			y	n	y		20
F. State plan for monitoring PSRO utilization review activities		n		y	y	n	n	n	n	y	y	y	y	n	y	n	y	y	p	n	y	y	y	y	p	y	y	n	n	y	y	y	y	y	y	c	y	n	y	y	y	y	y	y	n	p		n	y		y	y	n	p		32
G. Requiring identification of ordering physician on laboratory, x-ray, and prescription claims	y	c		y	y	y	y	y	y	c	p	y	y	y	y	y	c	y	y	y	y	n	n	y	y	y	c	y	y	y	y	y	y	y	y	c	y	y	y	n	c	y	y	n	y	y		y	y		y	p	y	y	y	46
H. Requiring participating providers to provide access to medical records	y	n		y	y	y	y	y	y	y	y	y	y	y	y	y	y	y	y	y	y	y	y	y	y	y	y	y	y	y	y	y	y	y	y	y	y	y	y	y	c	y	y	y	y	y		y	y		y	y	y	y	y	51
I. Patient education		n		y	n	n	n	n	y	p	n	n		y		c	y		y	y	c	n	n	n	n	c	y	y	n	p	y	y	n	p	y	y		n	p	n	d	c		n	n	y		c	d			y	h	y		22
J. Provider education	y	p		y	y	c	p	y	y	y	y	y		y	y	y	y	y	c	y	c	n	p	n	y	y	y	y	y	y	y	y	y	y	y	y	y	y	y	y	y	y	y	y	y	y		y	y			y	y	y		44

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Key: y = Yes; n = No; p = Proposed; d = Demonstration Basis; c = Certain Procedures, Services, or Recipient Categories

no Medicaid program

data not provided

data not provided

SELECTED STATE MEDICAID PROGRAM CHARACTERISTICS
Spring, 1982

II. UTILIZATION CONTROLS

K. Cost-sharing on:	AL	AK	AZ	AR	CA	CO	CT	DE	DC	FL	GA	GU	HI	ID	IL	IN	IA	KS	KY	LA	ME	MD	MA	MI	MN	MS	MO	MT
Audiological Exams																	$2[d]										V[n]	
Chiropractic Services															$1[p]	V[t]	50¢[d]	50¢						$1[h]				
Clinic Services																												
Dental Services															$1[p]	V[t]	$3[d]	50¢						$3[h]		$2	V[n]	
Dentures										5%[c]						V[t]	$3[d]										V[n]	
Drugs	V[o]			$1	$1[i]				50¢		V[b]			50¢	$1[p]	V[t]	50¢[d]	50¢			50¢[w]	50¢		50¢[q]		50¢	V[n]	50¢[x]
Emergency Rooms					$5[i]																							
Eyeglasses									$2							V[t]	$2[d]									$3	V[n]	
Hearing Aids										5%[c]							$3[d]							$3[h]			V[n]	
Inpatient Hospital Services																												
Inpatient Hospital Services in IMDs																												
Inpatient Psychiatric Services, 22 & under																												
Institutional Long Term Care																V[e]												
Medical Supplies & Equipment																V[t]	$2[d]											
Optometric Services															$1[p]	V[t]	$2[d]	50¢						$2[h]			V[n]	
Outpatient Hospital Services					$1[i]																							
P.T., O.T., Speech/ Hearing Therapy																V[t]	50¢[d]											
Physician Services																												
Podiatric Services											V[b]				$1[p]	V[t]	$1[d]							$2[h]			V[n]	
Private Duty Nursing																V[t]												
Prosthetic Services											V[b]					V[t]	$2[d]											
Psychiatric Services																V[t]												
Psychologist Services											V[b]					V[t]	$2[d]	50¢										
Rehabilitative Services																V[t]	$2[d]											
Transportation							V[b]				V[b]						$2[d]	50¢[s]								$3[s]		

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Key: V = Variable Copayment Schedule.

See following page for explanatory footnotes.

Note: Federal statute prohibits the levying of a copayment or deductibles on services to the categorically needy.

SELECTED STATE MEDICAID PROGRAM CHARACTERISTICS
Spring 1982

II. UTILIZATION CONTROLS

(CONTINUED)

K. Cost-sharing on:	NE	NV	NH	NJ	NM	NY	NC	ND	OH	OK	OR	PA	PR	RI	SC	SD	TN	TX	TT	UT	VT	VI	VA	WA	WV	WI	WY	Total all states
Audiological Exams																												2
Chirapractic Services		$1					50¢		$1[y]																	V[r]		7
Clinic Services		$1[m]					$1																			V[r]		3
Dental Services		$2[m]			$2		$2		50¢[y]						$1											V[r]		11
Dentures		$3																								V[r]		6
Drugs		$1			25¢		50¢		50¢[y]		$1[o]				50¢	50¢		50¢			$1[w]		50¢[z]		V[f]	V[r]		25
Emergency Rooms																								$2[j]				2
Eyeglasses		$3					$2	$3[g]	y														$2[h]			V[r]		10
Hearing Aids																												4
Inpatient Hospital Services							$2[k]																	u				2
Inpatient Hospital Services in IMDs		m																								V[r]		2
Inpatient Psychiatric Services, 22 & under																										V[r]		1
Institutional Long Term Care		m																										2
Medical Supplies & Equipment									50¢[y]																	V[r]		3
Optametric Services							$1[j]								$1											V[r]		8
Outpatient Haspital Services							$1[j]				$2[a]																	2
P.T., O.T., Speech/Hearing Therapy		$1							y																	V[r]		4
Physician Services							$1[j]				$2[a]																	1
Podiatric Services		$1							$1[y]						$1													7
Private Duty Nursing																										V[r]		2
Prosthetic Services		$3													V[b]													5
Psychiatric Services																												1
Psychalagist Services									$1[y]																	V[r]		5
Rehabilitative Services																										V[r]		3
Transportatian		$3/1[m]																								V[r]		7

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National Gavernars' Association
444 North Capital Street
Washington, DC 20001
(202) 624-5354

Key: V = Variable Capayment Schedule.

See fallawing page far explanatary faotnates.

Nate: Federal statute prahibits the levying af a copayment ar deductibles on services ta the categarically needy.

Footnotes for Table II. Utilization Controls,
Section K. Cost-Sharing

a. Alabama has a variable copayment on drugs, based on the drug cost (minus the $2.75 dispensing fee):

DRUG COST	COPAYMENT
$ .01 - 8.24	$ .50
$ 8.25 - 23.24	$1.00
$23.25 - 48.24	$2.00
$48.25 +	$3.00

At present, nursing home residents are exempt; this exemption may be affected by current litigation and/or HCFA determination.

b. The state has a sliding scale for copayments in line with the following federally allowed maximums cited in 42 CFR 447.54(a)(3):

PROGRAM COST	COPAYMENT
$10.00 or less	$ .50
$11.00 - 25.00	$1.00
$26.00 - 50.00	$2.00
$51.00 +	$3.00

c. Florida has a copayment of 5 percent on the total treatment cost of providing dentures to individuals 21 and over. For hearing aids, the state assesses a 5 percent copayment on the dispensing service, and a 5 percent copayment on the hearing aid itself.

d. Iowa's $2 copayment listed under "Prosthetic Services" is for orthopedic shoes. The 50¢ copayment listed under "P.T., O.T., Speech/Hearing Therapy" is for physical therapy only. The $2 copayment listed under "Transportation" is for ambulance service only. Iowa is currently exempting institutionalized individuals from the copayments and is negotiating with HCFA on this point.

e. Indiana charges copayments on ancillary services in long-term care facilities. The sliding scale is the same as in FOOTNOTE b.

f. West Virginia's copayment schedule for drugs is:

PROGRAM COST	COPAYMENT
Up to $10.99	$ .50
$11.00 and above	$1.00

Nursing home recipients are exempt.

g. North Dakota charges a $3.00 copayment for replacement of eyeglasses due to loss or breakage.

h. All individuals under 21 are exempt from the copayments.

i. Copayments on the indicated services for Medi-Cal recipients were implemented on May 10, 1982, upon HCFA approval. The emergency room copayment is charged only in cases of inappropriate use. Federal waivers were granted in order to make certain exceptions. Children and women seeking perinatal care are exempt from the copayments on emergency room and outpatient hospital services. Additionally, nursing home residents are exempt from the latter. Those groups exempt from the drug copayment are: children, the aged, those with chronic conditions, inpatients in a health facility, and Medicare recipients.

j. The copayment is paid only by medically needy recipients.

k. For inpatient hospital services North Carolina charges the medically needy $2 a day for the first thirty days per stay, with a maximum charge of 50 percent of the first day's cost.

m. In Nevada, the $2.00 copayment on dental services is charged for the initial dental exam only. The $1.00 copayment for clinic services is limited to mental health outpatient services. For inpatient hospital services in institutions for mental disease and for long term care facilities, a copayment of one-half of the first day's per diem is charged. SNF patients between 21 and 65 are exempted. Nevada charges a copayment of $3.00 per trip for ambulance services, $2 for medi-van, and $1.00 for taxi services.

n. Missouri implemented a variable copayment for the indicated services in October 1981. See FOOTNOTE b for the sliding scale. Foster children are exempt. As of July 12, 1982 the state will implement a copayment for drug prescriptions: For a prescription of up to $10.99, the charge will be 50¢; for a prescription of $11 or more, the charge will be $1.00.

o. Oregon has requested waivers from the federal government in order to impose copayments of $2 on physician and outpatient hospital services and $1 on drugs. These would apply to the categorically needy (Oregon does not have a medically needy program).

p. Illinois is considering implementation of a schedule of copayments for all non-institutionalized individuals, both categorically and medically needy. These are as follows: $1 copayments on drug prescriptions and visits to dentists, optometrists, podiatrists and chiropractors.

Illinois had applied for 1115 waivers to: a) allow imposition of these copayments on services provided to EPSDT recipients; b) exclude long term care patients from the copayment requirement; and c) exceed the federal maximum allowable flat copayment rate for drugs. The first of these was denied, but the second and third were granted. Illinois is presently reassessing the desirability of implementing this proposal, in light of the EPSDT waiver denial and its adverse effect on cost-effectiveness.

q. Michigan implemented a 50¢ copayment on certain brand-name drugs in February, 1981. It exempted individuals under 21 and long term care facility residents, and requested a waiver for the exemptions from HCFA. The Governor issued an Executive Order on May 20, 1982 directing the imposition of the 50¢ copayment on all prescriptions with the exceptions of drugs identified on the MAC list, drugs identified as generic substitutes for brand name products, and the aforementioned exemptions.

r. Wisconsin charges the maximum allowable copayments for the indicated services. These are based on the average fees in Wisconsin. Under "Clinic Services," the copay is for medical day treatment and under "Psychologist Services," for psychotherapy.

s. Copay on non-emergency ambulance only.

t. On August 1, 1981 Indiana implemented the variable copayment schedule listed in FOOTNOTE b for the indicated services (nursing home residents were exempt). On August 8 they were enjoined on technical grounds. The court has not yet rendered a final decision.

u. Washington imposes a deductible of $85 for each hospitalization for medically needy recipients.

w. Institutionalized individuals are exempt.

x. Montana allows each recipient two free prescriptions per month and, beginning with the third, he or she pays 50¢ per prescription.

y. Ohio plans to implement the indicated copayments in October, 1982. It applied for a waiver to exempt long term care and chronic care patients from these copayments. This waiver was denied and the state has yet to determine what course of action to take with respect to these groups. Copayments for eyeglass lens(es) will be 50¢, eyeglass frames - $1, and contact lens(es) - $1.50. The physical therapy copayment will be 50¢, and the charge for speech and audiology services will be $1.

SELECTED STATE MEDICAID PROGRAM CHARACTERISTICS
Spring, 1982

III. REIMBURSEMENT

	AL	AK	AZ	AR	CA	CO	CT	DE	DC	FL	GA	GU	HI	ID	IL	IN	IA	KS	KY	LA	ME	MD	MA	MI	MN	MS	MO	MT	NE	NV	NH	NJ	NM	NY	NC	ND	OH	OK	OR	PA	PR	RI	SC	SD	TN	TX	TT	UT	VT	VI	VA	WA	WV	WI	WY	Total y+c+d
A. Hospital																																																									
1. Reimbursement on other than Medicare "reasonable cost" principles	y	n		n	y	y	c	n	n	y	y	n	n	y	y	n	n	n	y	n	n	y	y	y	p	y	y	n	c	n	n	d	n	y	y	n	p	n	n	n	n	y	n	n	n	n		n	n		c	n	n	y		21
2. Denial of reimbursement for non-emergency weekend admissions	y	y		y	n	n	c	y	n	y	y	n	y	n		n		y	y	n	n	n	n	y	n	y	p	n	n	y	n	y	n	n	p	p	y	n	n	p	n		y	n	y	n		n	n		n	n	n	n		17
3. Denial of reimbursement for percentage contracts for lab and x-ray		n		n	n	n	n	n	n	n	n	n	y	n		n	n	n	y	n	n	n	n	n	n	n	n	p	p	n	n	n	n	n	n	n	n		n	n	n		n	n	y	n		n	n		n	y	n	n		4
4. Limiting reimbursement to rate of the least expensive setting		n		n	n	p	n	n	n	n	n	n	y	n		n	y	y	y	n	y	n	n	y	n	n	p	n	p	p	n	n	y	n	p	n	n		n	y	n		n	n	n	n		c	n		n	p	n	y		10
5. Tape-to-tape billing		y		p	n	y	n	p	y	y	y	n		p	p	y	y	y	n	y	p	c	y	y	p	y	p	p	y	p	p	y	p	y	p	y	d	n	p	n		p	y	y	y		n	y		n	y	p	y		25
6. Limiting laboratory reimbursement to high volume automated rate		n		n	n	n	n	n	c	n	n	n		n		n	n	n	n	n	n		y	n	n	n	n	n	p c	n	n	n	n	n	n	n	n	n	n	n		n	n	y	n		n	n		n c	p	n	y		4
7. Imputing an occupancy rate		n		n	p	n	n	n	n	y	n	n	y	y		n	n	n	p	n	n	y	y	n	n	p	n	n	n		n	n	n	y	n	n	n	n	n	n		n	n	p	n		n	n		n	n	n	y		7
B. Nursing Home																																																									
1. Establishment of rate ceilings	y	n		y	y	y	c	y	n	y	y	y		y	y	y	y	y	y	y	y	y	y	y	y	y	y	y	y	y	n	n	y	y	y	n	y	y	y	y	y	n	n	y	y		y	n		y	y	n	n	y	43
2. Limiting capital costs	y	n		p	n	y	y	n	n	n	y	n		p	y	y	y	y	y	y	n	n	y	y	y	y	p	y	n	y	n	y	n	y	n	y	n	y	y	n	y		y	y	n	y		y	y		y	y	p		31
3. Indexing reimbursement rates to economic trend factors	y	n		y	y	y	y	y	y	y	y	y		y	y	y	p	y	y	y	n	y	y	y	n	y	n	y	y	y	y	y	y	y	y	y	y	y	y	n	n	y	y	y	y		y	n		y	y	y	y		42
4. Reimbursement according to peer groupings	y	n		y	y	y	n	y	n	n	y	n		y	y	y	n	y	n	y	n	n	y	n	y	y	y	n	y		y	n	n	y	n	n	n	y	y	n	n		n	n	y	n		y	n		n	n	y	n		25
5. Tying reimbursement rates to grades of patient disability	n	n		y	c	n	n	n	n	y	n	n		n	y	n	y	y	n	n	n	n	y	n	y	y	n	p	p		n	y	n	n	n	n	y	n	n	y	n		n	n	n	y		y	n		n	y	y	y		17
6. Identical treatment of leased and owned facilities		y		n	y	n	y	y	n	n	n	n		y	y	y	n	y	y	y	n	y	y	y	y	c	y	p	y	y	y	y	y	y	y	n	y	y	n	n	y	n	y	n		y	y		y	n	y	n		33
7. Elimination of profit factor in reimbursement rates	y	n		y	n	n	n	y	y	n	n	n		n		n	n	y	n	n	n	n	n	n	n	c	y	y	n		y	n	n	y	n	n	n	y	y	y		n	n	n	n		y	y		p	n	n	n		16
8. Cap on administrative salaries	y	n		p	y	c	y	n	y	y	y	n		y	y	y	y	y	y	y	y	y	y	y	y	c	p	y	y	y	y	y	y	y	y	y	n	y	p	y	y	y	n	c	y		y	y		y	y	y	y		42

no Medicaid program

data not provided

data not provided

SELECTED STATE MEDICAID PROGRAM CHARACTERISTICS
Spring, 1982

III. REIMBURSEMENT
(CONTINUED)

	AL	AK	AZ	AR	CA	CO	CT	DE	DC	FL	GA	GU	HI	ID	IL	IN	IA	KS	KY	LA	ME	MD	MA	MI	MN	MS	MO	MT	NE	NV	NH	NJ	NM	NY	NC	ND	OH	OK	OR	PA	PR	RI	SC	SD	TN	TX	TT	UT	VT	VI	VA	WA	WV	WI	WY	Total y+c+d
B. Nursing Home (Continued)																																																										
9. Setting limits by cost centers, i.e., nursing, dietary, etc.	y	n		p	p	n	y	n	c	n	y	n		n		y	n	y		p	y	n	y	y	y	n	p	p	n	y	y	y	p	n	y	y	y	y	n	p	y	y	y	n	y		y	n		n	y	y	y		26
10. Limiting pass-throughs		n			p	n	c	n	n	n	y	n		y	y	y	n	y	c	n	n	n	c	n		n		y		c	y	n	n	y	n	n	y	y	y		y	p		y	y		y	y			y	y	y		23
11. Imputing a useful lifetime of 40 years on nursing home facilities		n		y	n	n	n	y	n	n	n	n		n		n	y	y		p	y	y	y	y	y	n	p	y	y	y	n	y	n	y	n	y	y		c	n	n	c	n		y	n		y	y	n	n		23
C. Physician Services																																																									
1. Limiting the number of billable procedures	n	n		y	n	n	c	y	n	y	y	n		n		n	n	y		y	n	n	y	n	y	y	y	n	n		n	n		n	y	n	y	y	n	y	n	y	y	n	n	n		n	y		y	y		21
2. Reimbursement at rate for service when it was delivered, not billed	y	y		y	y	y	y	p	y	y	y	y	y	y	y	y	n	y		y	y	y	y	y	y	y	y	n	y	y	y	y	y	n	y	y	y	y	y	y	y	y	y	n	y		y	y		n	y	y	y	y	45
3. Reimbursement at rate applicable where service was delivered, not billed	y	y		n	y	y	y	n	y	n	y	y	y	y	y	y	n	y	y	y	n	n	y	y	y	y	y	y		y	y	y	y	y	n	y	y	y	y	y	y	y	n	c	y		y	y		n	y	n	y		40
4. Price ceiling for disease episodes	n	n		n	n	n	n	n	n	n	n	n		n		n	n	n		n	n	n	n	n	n	n	n	n		n	n	n	n	n	n	n	n	n	n	y	n	n	n		n	n		n	n		n	n	n	n		1
5. Physician bonuses for use of less expensive hospitals, outpatient surgery, etc.	n	n		n	n	c	n	n	n	n	y	n		n		n	n	n		n	n	n	n	y	n	n	n	n		n	n	n	n	n	n	n	n	n	n	n		n	n	n	n		n	n		n	n	n	n		3
6. Reimbursement for office or ambulatory surgery at hospital operating room rate		n		n	c	n	y	n	n	n	y	n		n		n	n	n		y	y	n	n	n	n	y	y	n	n		c	c	y	n	n	n	n	n	n	n	n		n	n	n	n		n	n		n	n	n	n		10

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National Governors' Association
444 North Capitol Street
Washington, DC 20001
(202) 624-5354

Key: y = Yes; n = No; p = Proposed; d = Demonstration Basis; c = Certain Procedures, Services, or Recipient Categories

SELECTED STATE MEDICAID PROGRAM CHARACTERISTICS
Spring, 1982

IV. STATUS OF WAIVERS REQUESTED UNDER PROVISIONS OF PL 97-35

	CA	CO	CT	FL	GA	HI	IA	KS	KY	LA	ME	MI	MN	MS	MO	MT	NV	NH	NJ	NY	NC	OR	PA	RI	SC	SD	TN	UT	VT	VA	WA	WV	WI	Totals a	Totals d	Totals p
A. Freedom of Choice																																				
1. Primary care case management		a										2a 1p						p		p			2p					a			2d		p	4	2	6
2. Localities serving as brokers																																	p	0	0	1
3. Sharing of cost savings with recipients			d															d																0	2	0
4. Restricting recipients to cost-effective providers																				p											p			0	0	2
5. Unspecified											d			d					p														p	0	2	2
																																		4	6	11
B. Community-based LTC Programs	2d 2p	2p		2a	p	p	p	1a 1d 1p	2p	a			p		a	a	p			p	p	a		p	p	p	p		p	p		p		7	3	21

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National Governors' Association
444 North Capitol Street
Washington, DC 20001
(202) 624-5354

Key:
a = Approved by HCFA
d = Denied by HCFA
p = Pending decision by HCFA

Note: Table indicates number and status of waivers requested by states as of May 21, 1982. When only the status is given, the state has submitted only one waiver request in that area.

Benefit Packages

I. BENEFIT PACKAGES

A. General

CA *P 7/82 (-) California proposes to suspend for one year coverage of certain benefits for its Medically Indigent Adult category which is totally state funded. The outpatient services being considered for suspension include:

- chiropractic
- podiatry
- optometry/eye appliances and glasses
- psychology
- non-emergency medical transportation
- acupuncture
- physical therapy
- speech therapy
- occupational therapy
- audiology/hearing aids

CA *P 3/82 (-) The California legislature reported the introduction of a bill that would require legislative review of any benefit changes having fiscal impact of greater than $500,000 (AB1700).

CA *A 7/81 (+) California has implemented the Multipurpose Senior Services Project designed to evaluate the effects of providing, through a single program source, a comprehensive array of social and health services needed by persons 65 years of age or older who are immediately "at risk" of long-term institutionalization.

CO *P 2/82 (+) The Colorado legislature reports introduction of a bill to create a medically needy program limited to the following services: inpatient and outpatient hospital, home health, clinic, lab and x-ray, prescribed drugs, physicians, and rural health clinics (SB125).

KY *P 1/82 (-) The Kentucky legislature reported that a bill has been introduced to require that specific dollar amounts for each optional service be budgeted and appropriated (S129).

KY *A 11/81 (-) Kentucky required that payment for services rendered out of state meet certain criteria: services constitute medical emergency; travel to Kentucky would endanger patient's health; services are more readily available in another state; and it is the general practice for recipients to receive medical attention in another state. Exceptions are made for long term care recipients.

MN *A 3/82 (-) The Minnesota legislature passed a bill which gives the counties in the state greater incentives to enroll Medicaid recipients in HMOs by: 1) increasing from 90% to 95% the state match to counties for HMO enrollment fees; 2) guaranteeing coverage of the individual recipient for 6 months; and 3) instructing the state to seek a federal waiver to allow them to assess a coinsurance requirement on individuals who would have been accepted but chose not to enter an HMO (HF2123).

MS	*P	2/82	(-)	The Mississippi legislature reports the introduction of a bill to authorize the state to discontinue services or reduce reimbursement if federal funding is cut or eliminated (HB233).
MS	*A	/81	(-)	Mississippi raised to $76 million the amount of state funds which can be spent annually for its Medicaid program. By law, if expenditures exceed this amount, the state must terminate the payment of services through the program.
NH	*P	11/81	(+)	The State of New Hamphsire requested a federal waiver to exempt nursing home residents from the various service limitations it recently proposed. HCFA denied the state's application for a waiver of the Title XIX comparability requirement.
NM	*P	/82	(-)	New Mexico proposes to limit out-of-state services to those mandated by federal regulations.
NY	*D	9/80	(+)	The Metropolitan Comprehensive Care Program has as its key components the provision of improved access and continuity of care through the implementation of "Citycaid." The program will provide health care coverage to a maximum of 17,100 medically indigent and will develop a comprehensive case management system at Metropolitan Hospital. Ultimately it will become an HMO. Funding is 50% federal, 50% local.
NC	*A	12/81	(-)	North Carolina limited to 18 per year the total number of office visits a recipient could make to one or a combination of the following providers: outpatient hospital departments (excluding emergency rooms); rural health clinics; physicians; providers of family planning services; clinics (except for mental health centers); optometrists; podiatrists; chiropractors. The following diseases/treatments are excluded: • end-stage renal disease; • chemotherapy and/or radiation therapy for malignancy; • acute sickle cell disease; • end stage lung disease; • unstable diabetes; • hemophilia; • terminal stage or life-threatening illness; • pre-natal care; • EPSDT screens. There were previously no limits on these services.
OR	*P	/82	(-)	The Oregon legislature passed a law which expands the definition of Medical Assistance to include payments for insurance and other contractual arrangements and money paid to the recipient for the purchase of medical care (SB 889). However, the Medicaid agency has not as of yet implemented it.

UT	*P	1/82	(-)	The Utah state legislature has introduced a bill which provides that the state is not required to pay for Medicaid services when funds are unavailable or have not been appropriated (HB78).
WA	*A	7/81	(-)	Effective July 1, 1981 the State of Washington combined its medically needy and medically indigent programs into one program entitled the Limited Casualty Program (LCP). Not covered under this new program are: persons under 21 in foster care, subsidized adoptions, or institutions; pregnant women not qualifying for AFDC or SSI; two-parent families which fail to meet the non-financial standards for AFDC or SSI; or individuals who don't incur medical expenses equal to their excess income or resources as determined by the state's new regulations. Individuals are certified eligible for a maximum of three months. The LCP program is designed to provide limited scope medical care and covers only the following services: inpatient hospital services, OPD and rural health clinic services, physicians and clinic services, prescribed drugs, dentures, prosthetic devices, eyeglasses, SNF, ICF, and ICF-MR services, home health services, other lab and x-ray services, and medically necessary transportation. The services formerly covered under the state's medically needy program which are not covered under the LCP program are: EPSDT services, dental, chiropractic, outpatient physical therapy services except under home health care, and private duty nursing services. For those eligible for the LCP program based on its medically needy criteria, a deductible not to exceed one-half of the cost of the first day of inpatient hospital care is applied to each hospital admission. In addition, a patient co-pay or deductible of $3.00 is applied to each emergency room visit. For those qualifying for the LCP program under its medically indigent criteria, care is limited to treatment for acute and emergent conditions. A deductible of $1,500 for acute and emergent medical services per family in any twelve-month period is required. This is in addition to excess non-exempt income as defined by the state in its July 1, 1981 standards which must be applied to medical expenses.

B. Specific Services

1. Inpatient Hospital Services

AR	*A	3/82	(+)	Arkansas modified its inpatient hospital coverage limitation. The limitation, which is based on the average length of stay by diagnosis as determined by the Professional Activities Study (PAS) data for the Southern Region of the U.S., was changed from the 50th to the 75th percentile.
CA	*P	7/82	(-)	California proposes to tighten its definition of Medical Necessity for certain elective procedures, postponing those that are not necessary for protection of life or prevention of significant disability or serious deterioration of health.
CT	*P	2/82	(-)	The Connecticut legislature reports the introduction of a bill to: 1) prohibit non-emergency weekend admissions; 2) limit preoperative hospital stays to 1 day; 3) require preadmission lab tests; and, 4) require that the primary surgeon authorize assistant surgeon charges (H5235).
GA	*A	11/81	(-)	Georgia limited hospital coverage to 20 inpatient hospital days per recipient per fiscal year, including administrative days awaiting placement in a Skilled Nursing Facility or an Intermediate Care Facility (nursing home). Ancillary charges will be reimbursed beyond the 20-day limit if the 20-day limit is reached during an admission. Subsequent admissions will not be reimbursed.
GA	*A	11/81	(-)	Georgia limited to one the number of pre-operative inpatient hospital days allowed prior to elective surgery, unless medically justified.
GA	*A	11/81	(-)	Georgia began denying reimbursement for Friday, Saturday, and day-before-holiday hospital admissions except for emergencies and to those hospitals which have established weekend surgery programs. (Holidays: New Year's, July 4th, Labor Day, Thanksgiving, Christmas.)
IA	*A	6/82	(-)	Iowa prohibited payment for inpatient care in conjunction with certain surgical procedures which can be done on an outpatient basis.
IA	*A	4/82	(-)	Iowa limited reimbursement for inpatient hospital care to the 50th percentile of length of stay as indicated for recipient's diagnosis in Length of Stay in PAS Hospitals. Provision will be made for payment of longer stays in exceptional cases.
KS	*A	11/81	(-)	The State of Kansas restricted payment of an additional 67 surgical and diagnostic procedures to cases that are performed on an ambulatory basis. Documentation of medical necessity must now be attached to claims for payment on an inpatient basis for 137 procedures.

MD	*P	3/82	(+)	Maryland proposes to modify its 20-day limit per spell of illness in acute general hospitals by exempting recipients receiving shock-trauma or neo-natal care in the appropriate specialty referral units of those eleven Maryland hospitals which are designated as part of the Maryland Emergency Medical System.
MD	*P	2/82	(+)	The Maryland legislature reports introduction of bills to exempt neo-natal trauma, and burn patients from the twenty-day hospital limit (SJR58 and HJR102).
MD	*P	1/82	( )	The Maryland legislature reported the introduction of a bill exempting from hospital payment limits hospitalization for burns, shock trauma, and illnesses occurring at birth (HB708).
MA	*P	2/82	(-)	The Massachusetts legislature reported the introduction of a bill that would limit conditions for payment for administratively necessary days in hospitals (H3938).
MA	*P	2/82	(-)	The Massachusetts legislature has reported the introduction of a bill to eliminate non-emergency weekend admissions (H4810).
MA	*P	1/82	(+)	The Massachusetts legislature reports the introduction of a bill to authorize payment for administratively necessary days (H1777).
MI	*A	1/82	(-)	The State of Michigan is proposing to eliminate coverage of all Friday and Saturday non-emergency hospital admissions.
MI	*A	1/82	(-)	Michigan has dropped coverage of certain surgical procedures when performed in an inpatient hospital setting. These will be covered only in an ambulatory setting.
MI	*C	/82	(-)	The State of Michigan is considering limiting hospital stays for recipients with a diagnosis of substance abuse to three days for detoxification purposes, with prior authorization required for stays beyond the limitation.
MO	*P	4/82	(-)	Missouri has proposed to deny reimbursement for inpatient surgeries or diagnostic procedures that can be performed on an outpatient basis, excluding emergency admissions.
MO	*P	4/82	(-)	Missouri has proposed to disallow payment for one-day inpatient stays.
MO	*A	1/82	(-)	Missouri imposed a 21-day limit on inpatient hospital days for general relief recipients.
MO	*A	12/81	(+)	Missouri dropped its limitation of one pre-operative hospital day.
MO	*A	12/81	(-)	Missouri extended the limitation imposed on general assistance recipients of the 75th percentile of P.A.S. lengths of stay to all recipients.

NH	*A	9/81	(-)	New Hampshire dropped coverage of administratively necessary inpatient hospital days.
NJ	*D	5/82	(+)	New Jersey will conduct a demonstration project to provide service reimbursement for inpatient and outpatient alcoholism treatment centers. This has been approved by HCFA.
NJ	*P	2/82	(-)	The New Jersey legislature reports the introduction of a bill to permit hospitals to establish swing beds (S511).
NJ	*P	/82	(+)	The State of New Jersey has proposed to reimburse administrative patient days in non-DRG (Diagnosis-Related Groups) reimbursed hospitals.
NJ	*P	/82	(+)	The State of New Jersey has proposed to reimburse hospitals for administratively necessary patient days.
OH	*A	1/82	(+)	Ohio tightened its limitation on the number of covered inpatient hospital days per spell of illness from 60 days to 30 days, with additional days now allowed if they are medically necessary. (There was no previous extension for medical necessity.)
RI	*P	4/82	(-)	Rhode Island proposes to limit to five per hospitalization the number of allowed administratively necessary days provided in a hospital. After five, prior authorization will be required. Administratively necessary days are those days when a patient is no longer in need of inpatient hospital care and is awaiting placement in a community-based SNF or ICF.
RI	*A	/80	(-)	Rhode Island placed new limitations on inpatient hospital services: • Began requiring PSRO to certify services; • Began prohibiting coverage of elective cosmetic surgery and requiring prior authorization for cosmetic surgery for functional purposes; • Began requiring prior authorization for out-of-state services, with certain exceptions.
SC	*A	1/82	(-)	South Carolina reduced coverage of inpatient hospital days from 18 to 12 per year.
SD	*C	/82	(-)	South Dakota is considering a reduction in the number of allowable hospital inpatient days. The current limit is 60 days per benefit period.
UT	*C	/82	(-)	Utah is considering a proposal for a new limitation on covered inpatient hospital days per spell of illness which would be based upon PAS (Professional Activities Study) lengths of stay.
UT	*A	1/82	(+)	Utah eliminated its 28-days-per-stay hospital limitation.
UT	*A	7/81	(-)	Utah limited hospital days to 28 per stay.

VT	*A	79	(-)	Vermont eliminated coverage of inpatient hospital laboratory tests which are not specifically ordered by the patient's physician.
VA	*A	7/82	(-)	Virginia limited inpatient hospital coverage by allowing admission no more than one day prior to non-emergency surgery.
VA	*A	7/82	(-)	Virginia discontinued coverage of Friday and Saturday non-emergency hospital admissions.
WV	*A	1/82	(-)	West Virginia reduced its limitation on covered inpatient hospital days from 30 to 20 per year. In making the transition from calendar years to fiscal years as the basis for this limitation, they are allowing a maximum of ten inpatient hospital days for the period from January 1 to June 30, 1982.

2. Outpatient Hospital Services

FL	*P	1/82	( )	The Florida legislature reported that bills had been introduced to extend the pilot project to test the feasibility of increasing hospital outpatient service through local agency contributions (HB546 and S279). There are also discussions about dropping the project and lowering the $500 cap on services per year to the pre-1978 $100 level.
FL	*A	10/78	(+)	Florida increased the limit on reimbursement for outpatient hospital services from $100 to $500 per individual per fiscal year. At the same time, as part of a pilot project, Florida counties began contributing a percentage of their indigent care incomes to the state.
IA	*A	6/82	(-)	Iowa mandated that certain surgical procedures be performed on an outpatient basis, and prohibited payment for inpatient care in conjunction with those procedures when they are performed on an inpatient basis.
MD	*P	7/82	(+)	Maryland proposes to initiate coverage of psychiatric day treatment services in acute general hospitals.
MI	*A	1/82	(-)	Michigan has dropped coverage of certain surgical procedures when performed in an inpatient hospital setting. These will be covered only in an ambulatory setting.
MO	*P	3/82	(-)	Missouri imposed a restriction which allows only one emergency room/outpatient hospital facility charge per recipient per day.
MO	*P	3/82	(-)	Missouri has proposed to limit emergency room and outpatient visits to two per month, with an exception for those outpatient visits that would otherwise be performed on an inpatient basis, i.e., chemotherapy visits. (The majority of hospitals in Missouri do not have distinct parts for the emergency room as separate from the outpatient clinic. Therefore, the limitation is for any combination of such visits in a calendar month).
NH	*P	/81	(-)	New Hampshire applied for a waiver to drop the 12-visit-per-year outpatient hospital limitation and impose a $10.50 per visit copayment on outpatient services, exempting nursing home residents. The waiver was denied.
WI	*A	12/81	(-)	Wisconsin revised its definition of outpatient hospital services to include only mandatory services. All other optional services provided by outpatient hospital clinics may be limited as are comparable providers and services.
WI	*A	12/81	(+)	Wisconsin reinstated its coverage of outpatient mental health and alcoholism services, including psychotherapy services, when provided under contract with local community mental health boards.

3. Rural Health Clinic Services

KS	*A	7/81	(+)	Kansas adopted a policy which allows rural health clinics to be reimbursed for services performed by the physician extender in an adult care home – medical history, physical exam, patient rounds. Kentucky specified the conditions under which rural health clinics may participate in Medicaid. Clinics must be certified as a rural health clinic provider under Medicare and may provide any service that Medicare provides and other ambulatory services covered under Medicaid, if conditions for participation are met.

4. Laboratory and X-Ray

FL	*A	10/81	(-)	Florida deleted the limitation of a $50 maximum per recipient per fiscal year for Laboratory and Portable X-ray services. The lack of a cap should encourage use of independent labs, rather than labs associated with physicians' offices and outpatient facilities, who are reimbursed on a usual and customary basis.
MN	*A	/81	(+)	The State of Minnesota began coverage of chiropractic x-rays.
RI	*A	/80	(-)	Rhode Island added limitations to laboratory and x-ray services: • Charges will not be paid in cases where services could have been obtained free of charge from the Rhode Island Department of Health Laboratory; • Prior authorization required for special diagnostic and therapeutic x-rays which are not listed in the fee schedule.

5. Skilled Nursing Facility (SNF) for Individuals 21 and older

CA	*P	1/82	(-)	California proposes to increase paid leave days for nursing home patients in certain programs for the mentally disordered from 18 to 30 days per year, separately define "bed holds" as days when patients are in acute care facilities, and reduce reimbursement for all leaves and "bed holds" by $2.31 per day.
KS	*A	12/81	(-)	Kansas initiated statewide preadmission LTC screening. Payment for adult care home service will be made only if appropriate alternative services are not available.
KS	*A	7/81	(+)	Kansas adopted a policy which allows rural health clinics to be reimbursed for services performed by the physician extender in an adult care home -- medical history, physical exam, patient rounds.
KY	*A	6/81	(-)	Kentucky dropped Medicaid coverage of mental health center services provided to residents or patients of intermediate care facility and skilled nursing facilities.
MO	*A	8/81	(-)	Missouri dropped coverage of nursing home or state institutional care services for its general relief recipients.
NJ	*P	/82	(+)	The New Jersey legislature reports the introduction of bills to require nursing homes to reserve beds for up to 7 or 14 days when residents are temporarily hospitalized (S295 and S87).
SD	*C	/82	(-)	South Dakota is considering a reduction in the number of days for which beds may be reserved for nursing home patients on leave. The current limit is ten days for hospitalization. There is no limit for therapeutic home visits.
WV	*A	1/82	(-)	West Virginia ceased coverage of nursing home bed reservations during recipient absences.

6. Home Health Services

CO	*A	/81	(+)	Colorado implemented a new law (SB38) which provided for a pilot program of state-only funding for home health care for non-categorically eligible patients.
MI	*A	7/81	(+)	The State of Michigan began allowing for the first time enrollment of proprietary home health agencies.
MO	*P	3/82	(-)	Missouri has proposed to conduct pre-payment review of all home health claims to determine if the services are required in the patient's plan of care as signed by a physician.

7. Physician Services

GA	*A	11/81	(-)	Georgia limited physician reimbursement to one pre-operative hospital visit per recipient per hospital admission, unless more are medically justified.
GA	*A	11/81	(-)	Georgia began reimbursing for only those physician inpatient hospital visits made within the recipient's 20-day hospital limitation. Inpatient hospital visits will be reimbursed beyond the 20-day limitation if the 20-day limit is reached during an admission. Subsequent admissions will not be reimbursed.
GA	*A	11/81	(-)	Georgia limited coverage of physician office visits for pure family planning purposes to no more than two visits per recipient per fiscal year.
GA	*A	11/81	(-)	Georgia discontinued coverage of non-enrolled, out-of-state physicians for "term" obstetrical delivery, with certain exceptions.
GA	*A	11/81	(-)	Georgia restricted coverage of ultra-sound procedures in obstetrical care to only those maternity patients who are "high risk" patients (i.e., patient is under age 17 or over 35 or has certain medical complications supported by medical documentation).
IA	*P	7/82	(-)	Iowa has proposed removing coverage of intestinal or gastric bypass surgery for treatment of obesity.
IA	*A	6/82	(-)	Iowa prohibited payment for inpatient care in conjunction with certain surgical procedures which can be done on an outpatient basis.
IA	*C	/82	(-)	Iowa is considering removing transsexual surgery as a covered service on the basis that it is unproven/experimental surgery.
KS	*A	1/82	(+)	Kansas began covering intraocular lens implants, with prior authorization, for cataract patients 65 years of age and older.
KS	*A	11/81	(-)	The State of Kansas restricted payment of an additional 67 surgical and diagnostic procedures to cases that are performed on an ambulatory basis. Documentation of medical necessity must now be attached to claims for payment on an inpatient basis for 137 procedures.
MA	*P	2/82	(+)	The Massachusetts legislature reports that a bill has been introduced provide primary care services to recipients in long term care facilities (H1772).
MO	*P	3/82	(-)	Missouri has proposed to limit office visits to two per month, with exceptions allowed if the visit is documented on the medical necessity form and reviewed and approved by the Medicaid Medical Consultant. The intent of this provision is to limit recipient initiated contact, not physician-ordered and medically necessary visits. The latter are encouraged.

NJ	*A	7/81	(-)	New Jersey will no longer pay for physician services rendered to patients on a Friday or Saturday when they are admitted to a hospital on either of those days in the absence of specified medically necessary reasons.
RI	*A	/80	(-)	Rhode Island placed limitations on physicians' services: • No more than three family members may be treated in a physicians' office in one day. • Physicians visiting group care facilities may not treat more than six patients in one facility in one day.
SC	*A	7/81	(-)	South Carolina reduced coverage of physician visits, inclusive of outpatient hospital and emergency room care, from an unlimited number to 18 per year.
SD	*C	/82	(-)	South Dakota is considering placing a limitation on the number of physician visits allowed. The current criterion is medical necessity.
WI	*A	12/81	(+)	Wisconsin reinstated its coverage of outpatient mental health and alcoholism services, including psychotherapy services, when provided under contract with local community mental health boards.

8. Early and Periodic Screening Diagnosis and Treatment

CA	*A	11/80	(+)	California's Newborn Screening program was expanded to include testing for hypothyroidism and galactosemia as well as PKU.
MD	*A	2/82	(+)	Maryland began coverage of orthodontic services for participants in the EPSDT program who have a handicapping malocclusion.
MA	*P	/82	(+)	Massachusetts has proposed to establish regulation for family planning agencies to provide PGH (EPSDT) assessments.
MA	*A	7/81	(+)	Added coverage of PGH (EPSDT) health assessments when performed by a physician assistant under the direct supervision of a physician.
MI	*A	10/81	(-)	The State of Michigan has eliminated, for the EPSDT program, required face-to-face informing and completion of refusal documentation by field staff.
MO	*A	8/81	(-)	Missouri dropped coverage of EPSDT services for its general relief recipients.
OR	*A	1/82	(-)	Oregon revised EPSDT dental services by limiting visits to a periodicity schedule, by establishing priorities for care and by requiring prior authorization for non-emergency services.
TX	*P	9/82	(+)	Texas is proposing to reinstate a number of EPSDT dental services which were dropped in 1979. This action is in response to litigation which followed the reduction in services and which the state lost.
WI	*A	12/81	(-)	Wisconsin limited its coverage of EPSDT services to persons under 18 who are receiving or whose families are receiving cash payments.

9. Family Planning

GA	*A	11/81	(-)	Georgia limited coverage of physician office visits for pure family planning purposes to no more than two visits per recipient per fiscal year.
MO	*A	8/81	(-)	Missouri dropped coverage of family planning services for its general relief recipients.
TX	*A	3/81	(+)	Texas added genetic services as a benefit.

10. Intermediate Care Facility (ICF)

CA	*P	1/82	(-)	California proposes to increase paid leave days for nursing home patients in certain programs for the mentally disordered from 18 to 30 days per year, separately define "bed holds" as days when patients are in acute care facilities, and reduce reimbursement for all leaves and "bed holds" by $2.31 per day.
IN	*P	1/82	(+)	The Indiana legislature reported that a bill had been introduced to provide Medicaid reimbursement to the developmentally disabled for day developmental services in ICFs and ICFs/MR. These services include training in communication and social functioning, assistance in daily living activities, and provision of remunerative employment (SB359).
KS	*A	12/81	(-)	Kansas initiated statewide preadmission LTC screening. Payment for adult care home service will be made only if appropriate alternative services are not available.
KS	*A	7/81	(+)	Kansas adopted a policy which allows rural health clinics to be reimbursed for services performed by the physician extender in an adult care home – medical history, physical exam, patient rounds.
KY	*A	6/81	(-)	Kentucky dropped Medicaid coverage of mental health center services provided to residents or patients of intermediate care facility and skilled nursing facilities.
MO	*A	8/81	(-)	Missouri dropped coverage of nursing home or state institutional care services for its general relief recipients.
NJ	*P	/82	(+)	The New Jersey legislature reports the introduction of a bill to require nursing homes to reserve beds for up to 7 or 14 days when residents are temporarily hospitalized (S295 and S87).
NJ	*C	/82	(-)	New Jersey is considering recognizing only one level of ICF care in order to save on administrative costs.
SD	*C	/82	(-)	South Dakota is considering a reduction in the number of days for which beds may be reserved for nursing home patients on leave. The current limit is ten days for hospitalization. There is no limit for therapeutic home visits.
WV	*A	1/82	(-)	West Virginia ceased coverage of nursing home bed reservations during recipient absences.
WI	*P	2/82	(-)	Wisconsin has requested a waiver to permit the eventual phase out of the two lowest levels of ICF care. The state proposes to discontinue reimbursement for new admissions, except for persons with a diagnosis of chronic mental illness or developmental disability.

11. Intermediate Care Facility Services for the Mentally Retarded

CA	*P	1/82	(-)	California proposes to increase paid leave days for nursing home patients in certain programs for the mentally disordered from 18 to 30 days per year, separately define "bed holds" as days when patients are in acute care facilities, and reduce reimbursement for all leaves and "bed holds" by $2.31 per day.
FL	*A	7/81	(+)	Florida revised the levels of care in ICF-MRs to better define current residents. Increased staffing ratios to 1 to 2 for Developmental Institutional and Developmental/Residential residents and to 1 to 1 for Developmental/Non-Ambulatory and Developmental/Medical residents as required under 10D-38 of the Florida Administrative Code.
IN	*P	1/82	(+)	The Indiana legislature reported that a bill had been introduced to provide Medicaid reimbursement to the developmentally disabled for developmental services in ICFs and ICFs/MR. These services include training in communication and social functioning, assistance in daily living activities, and provision of remunerative employment (SB359).
NV	*A	10/81	(+)	Nevada has expanded its definition of rehabilitative services to include habilitative services provided (under auspices of Mental Retardation Division) to mentally retarded in small community-based residential facilities.
WI	*P	2/82	(-)	Wisconsin has requested a waiver to permit the eventual phase out of the two lowest levels of ICF care. The state proposes to discontinue reimbursement for new admissions, except for persons with a diagnosis of chronic mental illness or developmental disability.

12. Inpatient Psychiatric Services for Individuals under 22

MA	*P	2/82	(+)	The Massachusetts legislature reports that a bill has been introduced to provide coverage of persons under 21 in psychiatric hospitals (H1953).
MA	*P	2/82	(+)	The Massachusetts legislature reports the introduction of a bill to provide services for children in certain mental health facilities (H3139).
MO	*A	8/81	(-)	Missouri dropped coverage of state institutional care and inpatient psychiatric services for its general relief recipients.

13. Inpatient Hospital Services for those 65 + in an Institution for Mental Disease (IMD)

RI	*A	/80	(-)	Rhode Island began limiting coverage for individuals 65 or older in institutions for mental diseases to 150 days of care per year.

14. SNF Services for those 65 + in an IMD

RI	*A	/80	(-)	Rhode Island dropped nursing home care coverage for persons over 65 in institutions for tuberculosis or mental disease.

15. ICF Services for those 65 + in an IMD

RI	*A	/80	(-)	Rhode Island dropped nursing home care coverage for persons over 65 in institutions for tuberculosis or mental disease.

18. SNF Services for those 65 + in a TB Institution

RI	*A	/80	(-)	Rhode Island dropped nursing home care coverage for persons over 65 in institutions for tuberculosis or mental disease.

19. ICF Services for those 65 + in a TB Institution

RI	*A	/80	(-)	Rhode Island dropped nursing home care coverage for persons over 65 in institutions for tuberculosis or mental disease.

20. Personal Care Services

LA	*A	5/82	(+)	Louisiana began providing coverage of homemaker services on a time-limited, crisis basis when needed to maintain the recipient in the home.
MI	*A	7/81	(+)	The State of Michigan initiated coverage of personal care services provided in foster care or homes for the aged settings, including recipients in Department of Mental Health contract homes. Services must be prescribed by a physician, in accordance with a plan of treatment, and rendered by a qualified person under supervision of an RN. (Estimated annual state savings from FFP under Title XIX: $11.5 million.)
MO	*P	2/82	(+)	The Missouri legislature has introduced a bill to add coverage of personal care and adult day care services (HB1284).

21. Emergency Hospital Services

KS	*A	2/78	(-)	The State of Kansas limited payment of emergency room services to only actual emergency situations.
MI	*A	1/82	(-)	The State of Michigan no longer will cover non-emergency services rendered in a hospital emergency room.
MO	*P	3/82	(-)	Missouri has proposed to allow only one emergency room/outpatient hospital facility charge per recipient per day.
MO	*P	3/82	(-)	Missouri has proposed to limit emergency room and outpatient visits to two per month, with an exception for those outpatient visits that would otherwise be performed on an inpatient basis, i.e., chemotherapy visits. (The majority of hospitals in Missouri do not have distinct parts for the emergency room as separate from the outpatient clinic. Therefore, the limitation is for any combination of such visits in a calendar month).
WV	*A	1/82	(-)	West Virginia limited coverage of emergency room and associated ancillary services to conditions related to accident, injury or trauma.

22. Prescribed Drugs

AR	*A	10/81	(-)	Arkansas reinstated the 33-day quantity limitation on drug prescriptions.
CT	*P	2/82	(-)	The Connecticut legislature reports the introduction of bills to require providers to dispense generic drugs as substitutes for brand-name drugs (H5217and H9019X).
FL	*A	12/81	(-)	Florida included for reimbursement, in addition to most legend drugs, anti-arthritic buffered and enteric-coated aspirin when prescribed as an anti-inflammatory agent only. All non-steroidal drug products prescribed as an anti-arthritic, other than buffered or enteric-coated aspirin, will not be reimbursable unless the words "medically necessary" appear on the prescription in the physician's own handwriting prior to the submission of the claim. Excluded from reimbursement are: laxatives, topical acne preparations, and selenium sulfide preparations, and vitamins with the exception of fluorinated pediatric dosages, digestants except when prescribed for hepatic or pancreatic diseases, oral contraceptives unless prescribed for indications other than contraceptives, and achrostatin V caps, ananase, cyclospasmol, chymoral, combid, mycolog, mysteclin F, and papase.
GA	*A	11/81	(-)	Georgia limited the number of drug prescriptions to six per patient per month, except for life sustaining drugs by prior approval.
GA	*A	11/81	(-)	Georgia began requiring evaluation of new drugs on the market before they can be considered for addition to the formulary.
GA	*A	/81	(-)	Georgia removed the following drugs from their drug formulary: • all anti-rheumatics (arthritis medications) – replaced by enteric-coated aspirin; • all injectible drugs except certain painkillers, insulin, and certain anti-neoplastics; • all over-the-counter products except insulin and diabetic aids; • all legend laxatives.
IL	*A	6/81	(-)	The State of Illinois eliminated coverage of some over-the-counter drugs and supplies, such as dandruff shampoos, bandages, and adhesive tape. In Illinois, a physician's prescription had been required for coverage of such items under Medicaid.
IL	*A	/81	(-)	The State of Illinois placed increased emphasis on its policy requiring that each time a manufacturer seeks to add a new drug to the Program's formulary, the state opens up that entire therapeutic classification for review by its Pharmaceutical Panel and its Drug and Therapeutics Committee for the purpose of deleting inefficient drugs or high cost drugs for which lower cost substitutes are available.

IA	*A	7/80	(-)	Iowa removed coverage of prescribed laxative drugs.
KY	*P	/82	( )	Kentucky provided for the adoption of the U.S. FDA list containing drug products which are therapeutically equivalent with one another. It repealed all regulations of the Kentucky Drug Formulary Council setting forth therapeutically equivalent drug products which may be interchanged. It eliminated the requirements to distribute the generic drug formulary to practitioners and pharmacists.
MA	*A	3/82	(-)	Massachusetts no longer pays for preparations containing hexachlorophene, U.S.P., as the major active ingredient.
MA	*A	6/81	(-)	Massachusetts updated its List of Interchangeable Drugs, doubling the number of interchangeable drugs. Nearly 7,000 drugs appear in the List, including 135 of the 200 most commonly prescribed drugs in Massachusetts.
MI	*P	1/82	(-)	The State of Michigan will eliminate pharmacy coverage of laxative, antacid, antivertigo, vitamin (except pre-natal preps and pediatric fluoride drops), hematinic, and cough and cold legend drugs.
MI	*A	1/82	(-)	The State of Michigan has eliminated the exception policy for its drug formulary (see earlier entry). As a result, Ativan and Valium will no longer be covered under the state's Medicaid program.
MN	*A	/82	(-)	Minnesota will establish a drug formulary which will not include: drugs for which there is no federal funding; over-the-counter drugs, except for antacids, acetaminophen, family planning products, aspirin, insulin, prenatal vitamins, and vitamins for children under the age of seven; nutritional products; anorectics; and drugs for which medical value has not been established. Reimbursement will be the actual acquisition cost of the drug plus a fixed dispensing fee. Generic drugs shall be used unless the prescriber indicates "dispense as written" on the prescription.
MO	*P	10/82	( )	Missouri has proposed to develop an exception system with the fiscal agent and a drug utilization committee to identify cases where use of pharmaceuticals deleted from the formulary are clearly required. At that time, the state would propose to delete all the current exceptions from the five prescription limit.
MO	*P	2/82	(-)	Missouri has proposed to remove certain more costly brand names from its drug formulary.
NV	*P	3/82	(-)	Nevada presently covers three prescriptions per month plus those a physician designates as "emergency". The state proposes to delete coverage of "physician-designated emergency" prescriptions.

NH	*P	/81	(-)	New Hampshire applied for a waiver in order to drop the 3-per-month limitation on prescription drugs and to impose a $3.50 copayment per prescription for all recipients, with the exception of nursing home residents. The waiver was denied.
NC	*A	12/81	(-)	North Carolina placed a limitation on prescription drugs of four per month per recipient. Previously, there was no limit.
SC	*P	7/82	(+)	The South Carolina Health Care Planning and Oversight Commission has determined that, as of July, 1982, the Medicaid program will use an open formulary, covering all drugs listed in the F.D.A.'s National Drug Code (N.D.C.).
SC	*A	1/82	(-)	South Carolina reduced coverage of prescription drugs from four to three per month per recipient.
SC	*A	7/81	(-)	South Carolina reduced coverage of prescription drugs from an unlimited number to four per month per recipient.
SC	*A	7/81	(-)	South Carolina eliminated coverage of over-the-counter drugs.
TX	*A	4/82	(-)	Texas adopted a final rule, effective April 1, 1982, eliminating vitamins and anti-anemia drug products.
UT	*A	/81	(-)	Utah eliminated certain nongeneric drugs from coverage.
VA	*A	7/82	(-)	Virginia began requiring that all drug prescriptions be filled with generic items listed in the Virginia formulary.
WV	*A	3/82	(+)	West Virginia reinstated coverage of certain prescription drugs for medically needy recipients.
WV	*A	3/82	(-)	West Virginia reduced the number of drugs listed in the drug formulary.
WV	*A	1/82	(-)	West Virginia eliminated coverage of "minor" tranquilizers such as Valium, Librium, Azenes, and Activan.
WV	*A	1/82	(-)	West Virginia eliminated coverage of prescription drugs for medically needy recipients.
WV	*A	1/82	(-)	West Virginia eliminated coverage of non-legend drugs, with the exceptions of family planning products, insulin and syringes, and renal (ESRD) supplies.
WI	*A	7/81	(-)	Wisconsin eliminated its coverage of over-the-counter drugs, with the exception of antacids, insulin, and analgesics.

23. Dental Services

CA	*P	7/82	(-)	California proposes to limit Medi-Cal dental benefits provided to beneficiaries age 21 and older to emergency services, dentures, and repair of dentures.
IL	*A	11/81	(-)	The State of Illinois reduced its adult dental program to cover only emergency and certain restorative services.
IA	*A	7/80	(-)	Iowa limited posterior bridgework to very specific conditions.
KS	*A	1/82	(+)	Kansas added coverage of stainless steel crowns and annual dental exams for its adult population.
KS	*A	10/81	(-)	The State of Kansas limited complete dental services to EPSDT children only. Adult dental services are limited to oral surgery, dentures, x-rays, extractions, fillings, and related services.
KS	*A	7/81	(-)	The State of Kansas limited orthodontic treatment to EPSDT recipients.
KY	*A	1/82	(-)	Kentucky eliminated coverage of orthodontics procedures for individuals 21 and under.
KY	*A	1/82	(-)	Kentucky eliminated coverage of mileage charges billed by dentists in connection with services provided to individuals 21 and under.
KY	*A	1/82	(-)	Kentucky eliminated coverage of bridge work for individuals 21 and under.
KY	*A	1/82	(-)	Kentucky limited full mouth radiographs to one (1) every two (2) years per patient per dentist for individuals 21 and under.
KY	*A	1/82	(-)	Kentucky limited bitewing x-rays to four (4) per patient per year per dentist for individuals 21 and under.
KY	*A	1/82	(-)	Kentucky eliminated coverage of upper and lower dental plates for all ages.
KY	*A	1/82	(+)	Kentucky reimplemented coverage of diagnostic dental services for adults.
KY	*A	11/81	(+)	Retroactive to November, 1981, Kentucky reimplemented coverage of tooth extractions, fillings, and emergency treatment for adults.
KY	*A	11/81	(-)	Kentucky eliminated all dental services for adults 21 and older.

KY	*A	1/82	(-)	Kentucky eliminated coverage of stannous fluoride and dental sealant as an option to second fluoride treatment for patients under 21. Dental prophylaxis limited to one (1) per year for patients under 21.
MD	*A	2/82	(+)	Maryland began coverage of orthodontic services for participants in the EPSDT program who have a handicapping malocclusion.
NJ	*P	12/81	(-)	The State of New Jersey has proposed to limit the frequency of dental examinations, prophylaxic, flouride treatments and, the number of x-rays annually.
NC	*A	12/81	(-)	North Carolina placed a limit of one every five years upon full-mouth x-ray services.
OR	*A	12/81	(-)	Oregon redefined emergency dental care by placing a ceiling of $100 on the amount of such services covered in one month.
RI	*P	4/82	(-)	Rhode Island proposes to eliminate coverage of certain dental services, including bridgework, root canal therapy for bicuspids and molars, jacket crowns (except for fractured teeth), and extensive periodontal surgery and orgathnic surgery. (In the past, orgathnic and extensive periodontal surgery have been covered on an individual consideration basis only.)
RI	*P	4/82	(-)	Rhode Island proposes to limit the provision of orthodontic treatment to eligible AFDC children, Medically Needy Only children, SSI disabled children and foster children. (Orthodontic treatment is provided only in those cases which represent severe dental deformity and/or marked functional impairment.)
WI	*P	2/82	(-)	Wisconsin has requested a federal waiver to replace its current comprehensive dental benefit with a major/catastrophic dental benefit involving a deductible and coinsurance feature. The state would continue its present dental coverage for EPSDT-screened children and the elderly and disabled in nursing homes. (Anticipated annual savings: $7 million.)
WI	*A	12/81	(-)	Wisconsin established a requirement that a recipient pay the first $150 for dentists' services received in any year. The state would then pay 80% of the annual cost exceeding this amount, the recipient the remaining 20%. Excluded from this requirement are services provided through prepayment contracts, to patients in SNFs or ICFs, and to EPSDT-screened children.
WV	*A	1/82	(-)	West Virginia eliminated coverage of all dental services for recipients over 17 years of age.

24. Dentures

CT	*P	11/81	(-)	The Connecticut legislature reported that a bill has been introduced to limit provision of the following services to an as yet unspecified number per year: eyeglasses, eyeglass frames, and dentures (H0970X).
IA	*A	7/80	(-)	Iowa limited replacement of dentures to once every 5 years.
MO	*P	3/82	(-)	Missouri has proposed to disallow payment for denture adjustments and denture rebases when either or both services occur within six months of the date dentures were placed. This policy was recommended by the Dental Subcommittee of the State's Medical Advisory Committee.
NC	*A	12/80	(-)	North Carolina implemented a policy of allowing the initial reline of dentures only after six months have elapsed since the receipt of the dentures. Subsequent relines are allowed only at five-year intervals. Previously, there were no limits on denture relines.

25. Clinic Services

CA	*P	2/82	(+)	California is considering expansion of the extent of services minors may receive under Medi-Cal without parental consent or liability to include mental health and counseling services for minors determined mature enough to participate in the treatment and who would harm either themselves or others without treatment (not federally funded – state only funded).
FL	*A	2/82	(-)	Added community mental health services as a reimbursable service under 42 CFR 440.90, Clinic Services. Only outpatient services will be covered under this program. This will provide a less expensive alternative for provision of mental health services.
KY	*A	9/81	(-)	Kentucky began providing Medicaid reimbursement for covered outpatient and surgical services rendered by participating licensed outpatient surgical clinics.
KY	*A	6/81	(-)	Kentucky dropped Medicaid coverage of mental health center services provided to residents or patients of intermediate care facility and skilled nursing facilities.
MI	*C	/82	(+)	The Michigan Department of Social Services has undertaken discussions with the state's Department of Mental Health to explore the possibility of providing Title XIX coverage for clinic-based mental health services, including day treatment. This may become a coverage in its own right, or as part of a community-based LTC program.
NJ	*D	5/82	(+)	New Jersey will conduct a demonstration project to provide service reimbursement for inpatient and outpatient alcoholism treatment centers. This has been approved by HCFA.
NC	*A	12/81	(-)	North Carolina placed a limit of 18 per year upon the number of allowed visits to mental health centers. There was previously no limit.
PA	*A	3/82	(+)	Pennsylvania modified its policy toward methadone maintenance clinic services. In January, 1980 it limited visits to these clinics to six per week for three calendar months, after which the limit was to be reduced to three visits per week. This policy was challenged in court and never implemented. However, effective March, 1982, a limit of seven visits per week was imposed.
TN	*A	5/81	(+)	Tennessee expanded its coverage of clinic services to include medical and surgical services rendered by ambulatory surgical treatment centers.

26. Eyeglasses

CT	*P	11/81	(-)	The Connecticut legislature reported that a bill has been introduced to limit provision of the following services to an as yet unspecified number per year: eyeglasses, eyeglass frames, and dentures (H9070X).
IL	*A	6/81	(-)	The State of Illinois began enforcement of its policy of limiting coverage of eyeglasses to one pair per year per recipient with one allowable replacement.
IA	*A	7/80	(-)	Iowa limited replacement of eyeglasses to once every 2 years except when lost or broken.
KY	P	1/82	(-)	The Kentucky legislature reports the introduction of a bill to limit optometric services and eyeglasses to persons under age 21 (H578).
MA	*A	7/81	(-)	Massachusetts added new restrictions regarding stolen or lost eyeglasses which extended the previous replacement restriction period from 12 months to 18 months.
MI	*A	11/81	(-)	Through a competitive bid process, the State of Michigan has entered into a volume purchasing arrangement with Hess Optical Labs for eyeglass lenses and frames. The previous contractor was Bausch & Lomb.
MO	*P	3/82	(-)	Missouri has proposed to discontinue providing payment for replacement eyeglasses. It would allow only one pair of eyeglasses every two years.
MO	*A	11/81	(-)	Missouri imposed a copayment requirement on eyeglasses.
TX	*A	9/81	(+)	Texas added coverage of plastic lenses for eyeglasses when medically necessary.
VA	*A	7/82	(-)	Virginia discontinued coverage of podiatry, eyeglasses, and optometrists' services (with the exception of eye examinations).
WV	*A	1/82	(-)	West Virginia eliminated coverage of eyeglass cases.
WV	*A	1/82	(-)	West Virginia eliminated coverage of eyeglasses and examinations for eyeglasses for recipients over 17 years of age.

27. Optometrists' Services

KS	*A	10/81	(-)	Kansas dropped coverage of visual training therapy.
KY	P	1/82	(-)	The Kentucky legislature reports the introduction of a bill to limit optometric services and eyeglasses to persons under age 21 (H 578).
MO	*P	3/82	(-)	Missouri has proposed to allow one eye examination per year with no exceptions.
RI	*P	4/82	(-)	Rhode Island proposes to eliminate payment for optometry services (with the exception of eye examinations, refractions) for medically needy only recipients.
VA	*A	7/82	(-)	Virginia discontinued coverage of podiatry, eyeglasses, and optometrists' services (with the exception of eye examinations).
WV	*A	1/82	(-)	West Virginia eliminated coverage of eyeglasses and examinations for eyeglasses for recipients over 17 years of age.

30. Preventive Services

KY	*A	8/81	(+)	Kentucky began including well-child care as a basic primary care service. Early and Periodic Screening, Diagnosis, and Treatment is no longer a required medical service for Medicaid participation.
SC	*A	1/82	(-)	South Carolina ceased coverage of immunizations, with the exception of the EPSDT program.

31. Rehabilitative Services

CT	*P	2/82	(+)	The Connecticut legislature has reported the introduction of bills that would provide adult day care services to Medicaid recipients (H5337 and H5225).
FL	*P	/82	(-)	Florida submitted a waiver for approval by HHS to provide Medical Adult Day Health Care for SSI recipients over 18 years of age who are in danger of institutionalization or who are inappropriately placed in a long term care facility.
LA	*A	5/82	(+)	Louisiana began providing adult day health care services for individuals who might otherwise be hospitalized.
LA	*A	5/82	(+)	Louisiana added coverage of rehabilitative services provided by centers for the mentally retarded. These services are designed to develop personal, social, and employment skills. Six to eight hours of training are provided.
MA	*P	2/82	( )	The Massachusetts legislature reports the introduction of a bill to provide day care for the mentally ill as an alternative to institutionalization (S604).
MI	*C	/82	(-)	The Michigan Medicaid program is holding discussions with Michigan Rehabilitation Services on the subject of more effective use of monies of clients enrolled in both agencies' program. This would inlude elimination of possible double billing for service.
MN	*P	2/82	(-)	The Minnesota legislature reported the introduction of a bill to provide adult day care services as an alternative to institutionalization for persons who undergo preadmission screening (HF1307).
MO	*P	2/82	(+)	The Missouri legislature has introduced a bill to add coverage of personal care and adult day care services (HB1284).
NV	*A	10/81	(+)	Nevada has expanded its definition of rehabilitative services to include habilitative services provided (under auspices of Mental Retardation Division) to mentally retarded in small community-based residential facilities.
NJ	*D	5/82	(+)	New Jersey will conduct a demonstration project to provide service reimbursement for inpatient and outpatient alcoholism treatment centers. This has been approved by HCFA.
NJ	*P	2/82	(+)	The New Jersey legislature reports the introduction of a bill to expand coverage of alcoholism treatment (S792).
WI	*A	12/81	(+)	Wisconsin reinstated its coverage of outpatient mental health and alcoholism services, including psychotherapy services, when provided under contract with local community mental health boards.

32. Podiatrists' Services

GA	*A	11/81	(-)	Georgia limited coverage of podiatric office visits to 12 per fiscal year.
GA	*A	11/81	(-)	Georgia limited coverage of nail debridement (removal of dead or damaged tissue on the foot) to patients who are either diabetic or have peripheral vascular disease.
IL	*A	11/81	(-)	The State of Illinois eliminated coverage of podiatric consultations.
LA	*A	5/82	(-)	Louisiana limited its coverage of podiatric services to three services per recipient per calendar year. The term 'services' refers to individual procedures, more than one of which may be provided to a recipient in one visit.
MO	*P	3/82	(-)	Missouri has proposed to limit podiatric office visits to two per month, with exceptions allowed if the visit is documented on the Medical Necessity Form and reviewed and approved by the Medicaid Medical Consultant.
NM	*A	11/81	(-)	New Mexico limited podiatry services to the Medicare model.
RI	*P	4/82	(-)	Rhode Island proposes to eliminate payment for podiatry services for medically needy only recipients.
RI	*A	/80	(+)	Rhode Island added to covered podiatrists' services certain surgical procedures performed in the office or home.
VA	*A	7/82	(-)	Virginia discontinued coverage of podiatry, eyeglasses, and optometrists' services (with the exception of eye examinations).
WI	*P	2/82	(+)	The Wisconsin legislature reports the introduction of a bill to restore coverage of podiatrist services for the categorically and medically needy (AB1032).
WI	*A	9/81	(-)	Wisconsin dropped its coverage of podiatric services.

33. Chiropractors' Services

MI	*P	1/82	(-)	The State of Michigan has proposed eliminating chiropractic services as a covered benefit.
MN	*A	/81	(+)	The State of Minnesota began coverage of chiropractic x-rays.
SC	*A	1/82	(-)	South Carolina eliminated coverage of chiropractic services.

34. Other Practitioners

AK	*A	10/81	(+)	The State of Alaska added coverage of nurse-midwife services.
GA	*A	1/82	(-)	Effective January 1, 1982, Georgia limited coverage under the Psychology Program to no more than five hours of psychological therapy and/or evaluation and testing per recipient per calendar year. The previous $250 limitation remained in effect for services rendered prior to January 1, 1982.
IA	*A	5/82	(+)	Iowa has proposed adding coverage of independently practicing psychologists.
MD	*P	7/82	(+)	Maryland proposes to initiate coverage of psychiatric day treatment services in acute general hospitals.
MA	*P	1/82	( )	The Massachusetts legislature reported that a bill has been introduced to allow nurse practitioners to provide care in nursing homes and home care settings (S486).
MA	*P	1/82	(+)	The Massachusetts legislature reports that a bill has been introduced to provide reimbursement to RNs for services otherwise reimbursed to other practitioners (H1778).
MA	*A	7/81	(+)	Added coverage of PGH (EPSDT) health assessments when performed by a physician assistant under the direct supervision of a physician.
MS	*A	7/81	(?)	Mississippi added coverage of nurse-midwife services. At present, they are reimbursing clinics and hospitals for these services, but are not reimbursing these providers directly on a professional fee basis, pending issuance of federal regulations.

35. Private Duty Nurse

NM	*A	11/81	(-)	New Mexico eliminated coverage of private duty nursing services.

36. Physical Therapy

AL	*A	4/81	(-)	Alabama imposed new limitations on physical therapy, covering it only by prior authorization from the Alabama Medicaid Agency and based on medical necessity. Physical therapy is covered only when given by a physician or under his direct supervision, or in a hospital outpatient setting.
MI	*P	1/82	(-)	Steps are underway within Michigan to implement direct enrollment of physical therapists as providers. Coverages are not affected, but better control over billing and Medicare payments will be achieved.
MO	*P	2/82	(-)	Missouri has proposed to establish computer edits to enforce policy limit payments for physical and occupational therapy to adaptive therapy in the use of a prosthetic or orthotic device.

37. Occupational Therapy

MO	*P	2/82	(-)	Missouri has proposed to establish computer edits to enforce policy to limit payments for physical and occupational therapy to adaptive therapy in the use of a prosthetic or orthotic device.

38. Speech, Hearing, and Language Disorders

MO	*P	3/82	(-)	Missouri has proposed to allow only one audiological examination for a hearing aid every four years unless a Medical Necessity Form is attached and completed properly and approved by the Medicaid Consultant. This measure is endorsed by the Audiology Subcommittee of the state's Medical Advisory Committee.
NM	*A	12/81	(-)	New Mexico limited coverage of speech therapy services to those providers covered by Medicare. In doing so the state eliminated coverage of independent speech therapist services.
OR	*A	3/82	(+)	Oregon added certain speech therapy services for all ages. Prior authorization is required except for the initial evaluation.
OR	*A	1/82	(+)	Oregon added coverage for adults of hearing aid services provided by audiologists and hearing aid dealers.

39. Prosthetic Devices

NY	*P	2/82	(+)	The New York legislature reports the introduction of a bill to provide hearing aids to deaf persons (A9975).
UT	*A	/81	(-)	Utah limited coverage of orthopedic shoes to those attached to a brace or prosthesis.

42. Durable Medical Equipment and Supplies

GA	*A	11/81	(-)	Georgia eliminated coverage for the special payment category "Miscellaneous Medical Supplies" and reduced the maximum number of medical supplies covered per month.
IA	*P	4/82	(-)	Iowa has proposed mandating purchase of used equipment when available and appropriate.
MO	*P	4/82	(-)	Missouri has proposed to limit DME Medicare/Medicaid crossover claim payments to only those items that are covered by the state Medicaid program.
NV	*A	10/81	(-)	Nevada no longer purchases liquid oxygen for use in the home.
SC	*A	7/81	(-)	South Carolina restricted coverage of durable medical equipment to match Medicare guidelines.

43. Transportation

KS	*A	12/81	(-)	The State of Kansas limited non-ambulance transportation to EPSDT children, recipients who are receiving services which keep them out of hospitals and nursing homes, and other recipients for trips of at least 50 miles if there is a physician referral.
OR	*A	2/82	(-)	Oregon established priorities for non-emergency transportation. That is, it defined those situations in which it would pay for transportation and those in which it would not but would find alternate sources. Non-emergency transportation must be pre-authorized. A class action suit has been filed against this policy, and its final resolution is unclear.
RI	*P	4/82	(-)	Rhode Island proposes to eliminate payment for ambulance services for medically needy only recipients.
RI	*A	/80	(+)	Rhode Island added coverage of various modes of transportation (previously, only ambulance service was provided): • Senior Citizens' Transportation Services; • Transportation provided by SNF's and ICF's for their ambulatory patients (payment for maintenance of vehicles included in their per diem rate); • Transportation secured by the local welfare office when neither the patient nor the program can obtain it free of charge. The state also began requiring prior authorization for ambulance service for nonambulatory SNF and ICF residents.

Utilization Controls

II. UTILIZATION CONTROLS

A. General

CA *P 3/82 (-) The California legislature reported the introduction of a bill that would require providers who have been ordering unnecessary services to receive prior authorization (AB528).

CT *P /82 (-) The Connecticut legislature reports that bills have been introduced to establish copayments on various types of services. One bill (H9069X) would set these copays on medically needy optional services:

- non-institutional services

Copay	Service Payment
$ .50	$10 or less
1.00	$11 to $25
2.00	$26 to $50
3.00	$51 or more

- institutional services – copay of 50% of cost of first day of care.

Another bill (H5221) would require the Department of Income Maintenance to establish copays on all services.

FL *A 10/81 (-) The State of Florida is implementing procedures for pre-admission screening for all individuals seeking Medicaid coverage of nursing home care in three areas of the state – Districts IV, VI and XI.

HI *P 1/82 (-) The Hawaii legislature reported the introduction of a bill that would require public assistance recipients to pay 10% of the first $200 of medical costs incurred each month (SB2928-82).

IL *P /82 (-) The State of Illinois has proposed to implement $1.00 co-payments on all drug, dental, optometric, podiatric, and chiropractic services provided to both catagorically-related and medically needy recipients.

Federal 1115 waivers have been requested to a) allow imposition of co-payments on services provided to EPSDT recipients; b) exclude long term care patients from the co-payment requirement; and c) exceed the federal maximum allowable flat co-payment rate for drugs.

The savings in state funds anticipated from the imposition of these co-payments is estimated to be $20 million for the fiscal year beginning July 1, 1982.

IA *A 4/82 (-) Iowa Medicaid received a mandate from the legislature to review prior authorization requirements.

MA	*A	9/81	(-)	The State of Massachusetts has developed a new Managed Health Care program which incorporates the present case management program (a fee-for-service project in which primary care providers must authorize all services) and the present health maintenance organization program (a capitation project) along with a new initiative to develop capitated fiscal intermediaries who subcontract for the provision of health services.
MO	*P	1/82	(-)	The Missouri legislature reported the introduction of a bill to institute both lock-in and lock-out programs (HB1953).
NV	*A	10/81	(+)	All recipients in institutional or substitute care (SNF, ICF, AGCF, foster care) are exempt from the co-payment indicated for specific services in this section.
NJ	*C	/82	(-)	The Governor of New Jersey proposed in his budget that fixed-rate copayments be required for selected optional services, with an exemption for institutionalized recipients.
NM	*C	/82	(-)	New Mexico is considering imposing copayments on many optional services.
OH	*P	/82	(-)	Ohio Medicaid, by state legislative mandate, proposed imposition of copayments on a number of optional services, including: vision care, dental services, psychology, speech and audiology, medical supplies, prescription drugs, podiatry, and chiropracty. The state is seeking federal approval to exempt residents of nursing homes and persons with chronic conditions from these copayments. The state has also applied for a waiver to impose copayments on certain mandatory services, such as physician and outpatient hospital services.
VA	*A	7/82	(-)	Virginia instituted the maximum allowable copayments for all services provided to medically needy recipients. (This includes copayments for drugs and transportation on a sliding scale.)
WA	*A	7/81	(-)	Effective July 1, 1981 the State of Washington combined its medically needy and medically indigent programs into one program entitled the Limited Casualty Program (LCP). Not covered under this new program are: persons under 21 in foster care, subsidized adoptions, or institutions; pregnant women not qualifying for AFDC or SSI; two-parent families which fail to meet the non-financial standards for AFDC or SSI; or individuals who don't incur medical expenses equal to their excess income or resources as determined by the state's new regulations. Individuals are certified eligible for a maximum of three months. The LCP program is designed to provide limited scope medical care and covers only the following services: inpatient hospital services, OPD and rural health clinic services, physicians and clinic services, prescribed drugs, dentures, prosthetic devices, eyeglasses, SNF, ICF, and ICF-MR services, home health services, other lab and x-ray services, and medically necessary transportation. The services

formerly covered under the state's medically needy program which are not covered under the LCP program are: EPSDT services, dental, chiropractic, outpatient physical therapy services except under home health care, and private duty nursing services.

For those eligible for the LCP program based on its medically needy criteria, a deductible not to exceed one-half of the cost of the first day of inpatient hospital care is applied to each hospital admission. In addition, a patient co-pay or deductible of $3.00 is applied to each emergency room visit.

For those qualifying for the LCP program under its medically indigent criteria, care is limited to treatment for acute and emergent conditions. A deductible of $1,500 for acute and emergent medical services per family in any twelve-month period is required. This is in addition to excess non-exempt income as defined by the state in its July 1, 1981 standards which must be applied to medical expenses.

WI	*P	2/82	(-)	Wisconsin has requested a federal waiver to encourage provider/recipient risk-sharing through a phased-in lock-in provision that offers at least one HMO or prepayment option to all Medicaid recipients. The costs are expected to be at or below the current statewide average per capita expenditure and thus lower overall. All qualified providers will have an opportunity to compete. (Estimated annual savings: $20 million.)
WI	*P	12/81	(-)	The Wisconsin legislature passed a law requiring the state to impose the maximum allowable recipient cost-sharing requirements (including copayments, coinsurance, and deductibles) on both mandatory and optional services. Excluded from this requirement are recipients receiving care under a prepayment contract, individuals in SNFs or ICFs, and children in subsidized adoptions or foster care placements. The legislature mandated the state Medicaid agency to apply for federal waivers to allow the imposition to allow the imposition of cost-sharing requirements on mandatory services. The agency has submitted the necessary waiver requests.

B. Specific Services

1. Inpatient Hospital Services

CA	*A	11/81	(-)	California law now specifies that all emergency hospital admissions require approval and are subject to review by Department of Health Services staff after 24 hours rather than 3 days, in order to decrease unnecessary hospitalization.
CA	*A	7/81	(-)	California is working with the Hospital Association and with individual hospitals in an effort to reduce nosocomial infections. Reduction in the rate of infection will result in shortened hospital stays, thereby reducing costs.
CO	*A	/81	(-)	Colorado established concurrent utilization review for hospital admissions.
CO	*A	/81	(-)	The Colorado legislature passed a bill (SB525) which requires the Medicaid agency to consider providing reimbursement incentives to physicians for decreasing recipient utilization of inpatient hospital services.
GA	*A	11/81	(-)	Georgia implemented a 100% review of inpatient hospital claims prior to payment, effective January 1, 1982.
KS	*P	1/82	(-)	The State of Kansas has proposed to review inpatient ancillary services.
KS	*A	4/82	(-)	Kansas ended, as of April 1, 1982, its reliance on PSRO's for hospital utilization review. The state is negotiating with several groups in the state to take over the reviews, but in the interim they will be conducted by the individual hospitals. The state is tightening its length of stay regulations. All inpatient hospital stays for Medicaid recipients must be reviewed and be deemed medically necessary, with backup documentation of the review. For those recipients whose lengths of stay equal or exceed the 75th percentile of stays for their primary diagnosis as listed in the most recent edition of the PAS, North Central Region, a Medical Necessity Form must be attached to the claim.
KY	*A	/81	(-)	The Governor of Kentucky established a 2½ year moratorium on acute-care hospital bed expansion in the two largest metropolitan areas of the state.
MD	*A	7/81	(-)	The State of Maryland instituted a 100 percent review of inpatient hospital admissions and a pre-admission review for elective admissions and assignment of length of stays.
MI	*A	1/82	(-)	Michigan is allowing its contracts with the ten Michigan PSRO's to expire. The state will conduct its own utilization review of hospitals, which they anticipate will be less costly and more effective.
MI	*C	/82	(-)	The Michigan Medicaid program is considering allowing nurse practitioners to certify/recertify inpatient stays for hospitals and nursing homes.

MI	*P	1/82	(-)	The State of Michigan has proposed to review all inpatient hospital claims that exceed the 75th percentile of length of stay criteria.
MI	*C	/82	(-)	The State of Michigan is considering limiting hospital stays for recipients with a diagnosis of substance abuse to three days for detoxification purposes, with prior authorization required for stays beyond the limitation.
MO	*P	4/82	(-)	Missouri has proposed to implement a state utilization review program to replace utilization review as performed by the Professional Standards Review Organizations (PSRO's).
NE	*P	1/82	(-)	Nebraska has proposed to revise its physicians' handbook to more clearly define hospital length of stay and utilization review criteria. (Estimated Savings: $975,000.)
NH	*A	10/81	(-)	New Hampshire Medicaid assumed the functions previously performed by PSRO's.
PA	*A	6/82	(-)	Pennsylvania is phasing out its use of PSRO's for hospital utilization review (as contracts with PSRO's expire, they are not being renewed). By June, 1982 the transition will be complete, and the Medicaid program will be conducting its own utilization review.
RI	*P	4/82	(-)	Rhode Island is considering a proposal to institute its own program for utilization review of hospitals. It will no longer contract with a PSRO to provide this service.
RI	*A	/80	(-)	Rhode Island placed new limitations on inpatient hospital services: • Began requiring PSRO to certify services; • Began prohibiting coverage of elective cosmetic surgery and requiring prior authorization for cosmetic surgery for functional purposes; • Began requiring prior authorization for out-of-state services, with certain exceptions.
VA	*A	/81	(-)	The Virginia legislature approved a provision to develop a plan for reducing the number of surplus hospital beds. A study is currently underway.

2. Outpatient Hospital Services

AL	*C	/82	(-)	Alabama is considering a lock-in of abusers of outpatient hospital services to one provider. Alabama currently has a limitation on non-emergency outpatient hospital visits of six per year; the purpose of this proposal would be to assist hospitals in avoiding nonpayment for services to overutilizers who have surpassed their visit limitation.
MI	*C	/82	(-)	The State of Michigan is considering the imposition of a $5.00 copayment on all non-emergency outpatient hospital visits.
NH	*P	/81	(-)	New Hampshire applied for a waiver to drop the 12-visit-per-year outpatient hospital limitation and impose a $10.50 per visit copayment on outpatient services, exempting nursing home residents. The waiver was denied.
NJ	*A	3/82	(-)	New Jersey began requiring prior authorization for out-of-state non-emergency inpatient or outpatient hospital care.
OR	*C	/82	(-)	Oregon is considering the imposition of copayments on visits to clinics and hospital outpatient facilities, as well as to physicians. These would require waivers from the federal government.
RI	*A	/80	(-)	Rhode Island began requiring prior authorization for occupational therapy in a hospital outpatient setting.
WA	*P/W	/82	(-)	Washington requested a freedom of choice waiver seeking to implement a $5.00 copayment for emergency hospital and outpatient hospital visits for all Medicaid recipients, except residents of institutions. HCFA disapproved this request, stating that the legislative provision referenced provided no authority to approve waivers for copayments.

4. Laboratory and X-Ray

MI	*A	4/82	(-)	Michigan began closely reviewing laboratory services for above average use. A provider suspected of abuse will be referred for possible audit and recovery of funds.
RI	*A	/80	(-)	Rhode Island added limitations to laboratory and x-ray services: • Charges will not be paid in cases where services could have been obtained free of charge from the Rhode Island Department of Health Laboratory; • Prior authorization is required for special diagnostic and therapeutic x-rays which are not listed in the fee schedule.

5. Skilled Nursing Facility (SNF) for Individuals 21 and older

CA	*P	3/82	(+)	The California legislature reports introduction of a bill to exempt certain income from cost-sharing for long term care residents (AB240).
CO	*A	/81	(-)	The Colorado Medicaid agency altered the triage system which assesses clients for suitability for alternative care prior to nursing home placement.
CT	*P	2/82	(-)	The Connecticut legislature reported a bill to create a mandatory prescreening program for persons leaving a hospital prior to entering a nursing home (H5355).
IN	*P	1/82	(-)	The Indiana legislature reports the introduction of a bill to establish a LTC preadmission screening program (HB1304).
KY	*A	/81	(-)	The Governor of Kentucky extended the statewide freeze on nursing home bed expansion through December, 1983.
MA	*P	2/82	(-)	The Massachusetts legislature has reported the introduction of a bill to deny reimbursement to any newly constructed nursing home (H4811).
MN	*D	/81	(-)	Minnesota initiated a preadmission screening program for Medicaid recipients seeking admission to SNFs and ICFs. Alternative community care, if no more costly, is offered as an option. A waiver is being applied for regarding home and community-based services.
MN	*A	3/82	(-)	The Minnesota legislature passed a bill which would expand the state's LTC preadmission screening program to include persons being discharged from hospitals (HF2063).
MS	*A	7/80	(-)	Mississippi placed a cap of 100 on the number of nursing home beds per 1,000 Medicaid recipients for which they would provide reimbursement. The resulting total number of beds was then allocated among individual facilities. The cap was in effect for one year, but in July of 1981 the federal government asked them to cease. Mississippi has appealed the ruling, and a hearing will be held in April, 1982.
UT	*A	/81	(-)	Utah began requiring preadmission screening for recipients seeking to enter SNFs.
VA	*A	6/81	(-)	Virginia established a one-year moratorium on granting Certificates of Need (CON) for new nursing home beds.
WA	*A	12/81	(-)	The State of Washington's Utilization Review/Utilization Control staff initiated a physician recertification turn-around document to simplify the task of documenting 60-day physician recertification of the continued need for nursing home care.

WA	*A	12/81	(-)	Under federal waivers, the State of Washington has reduced the frequency of nursing home post-survey visits, extended the period of licensing/certification from one year to up to three years, and eliminated paper compliance monitoring.
WA	*A	12/81	(-)	Under federal waivers, the State of Washington has eliminated Medical Care Evaluation studies and cut back the number of Utilization Review/Utilization Control visits to SNF patients, extending the visit period up to one year.
WI	*P	2/82	(-)	Wisconsin has requested a federal waiver to modify its LTC utilization control and survey and certification processes. The modifications sought have already been validated through a four-year 1115 demonstration. The plan would reduce the paperwork burden on nursing home operators and state and federal staff, allow more flexibility in the timing of inspections and afford a more realistic policy for plans of correction. (Anticipated annual savings: $6 million.)

7. Physician Services

CA	*P	2/82	(-)	The California legislature reports the introduction of a bill to require second opinions on elective surgeries (SB1517).
CA	*A	1/82	(-)	California's Beneficiary Utilization Review Unit expanded its activities to include review of beneficiaries who are suspected of over-utilizing or abusing medical office visits. Recipients found to be overutilizing or abusing will be placed on "restriction" for 24 months, and prior authorization will be required for affected services.
CT	*P	10/82	(-)	Connecticut is proposing to implement a lock-in of high utilizers to one physician and to a single provider of any other service which they overutilize. Connecticut already has a pharmacy lock-in program.
CT	*P	2/82	(-)	The Connecticut legislature reports the introduction of bills to require second opinions for certain elective surgeries (H5224 and HB212).
GA	*A	11/81	(-)	Georgia added hysterectomy and excision of varicose veins to the list of procedures provided by physicians which require prior approval.
ME	*P	3/82	(-)	Maine established a prior authorization requirement for services related to gastric bypass or gastroplasty surgery. It must now be shown that the recipient meets certain requirements relating to weight, other weight loss efforts, and the existence of certain medical conditions.
MI	*A	/80	(-)	Michigan established a list of nine elective surgical procedures for which second opinions are required. Subsequently, two procedures were dropped from the list.
MO	*P	1/82	(-)	The Missouri legislature reported the introduction of a bill to require prior authorization for surgery (HB1089).
MO	*A	/82	(-)	Missouri is expanding its lock-in program which restricts recipients to one provider.
NJ	*A	2/81	(-)	New Jersey adopted a recipient lock-in system for overutilizers of physician and pharmacy services.
NC	*A	3/82	(-)	North Carolina instituted recipient lock-ins for over-users of physicians' and pharmacists' services.
PA	*P/W	/82	(-)	Pennsylvania has requested a freedom of choice waiver in order to identify and assign "overutilizers" to a physician who would be solely responsible for their care.
WA	*A	2/82	(-)	Washington began requiring a second opinion for specific elective surgical procedures.

WA	*A	1/82	(-)	The State of Washington survey staff, under a federal waiver, reduced the frequency of physician visits required for nursing home patients for monitoring purposes.
WV	*P	/82	(-)	West Virginia has requested a waiver in order to impose copayments for physician services.

8. Early and Periodic Screening Diagnosis and Treatment

OR	*A	1/82	(-)	Oregon revised EPSDT dental services by limiting visits to a periodicity schedule, by establishing priorities for care and by requiring prior authorization for non-emergency services.

10. Intermediate Care Facility (ICF)

CA	*P	3/82	(+)	The California legislature reports introduction of a bill to exempt certain income from cost-sharing for long term care residents (AB240).
CO	*A	/81	(-)	The Colorado Medicaid agency altered the triage system which assesses clients for suitability for alternative care prior to nursing home placement.
CT	*P	2/82	(-)	The Connecticut legislature reported a bill to create a mandatory prescreening program for persons leaving a hospital prior to entering a nursing home (H5355).
IN	*P	1/82	(-)	The Indiana legislature reports the introduction of a bill to establish a LTC preadmission screening program (HB1304).
KY	*A	/81	(-)	The Governor of Kentucky extended the statewide freeze on nursing home bed expansion through December, 1983.
MA	*P	2/82	(-)	The Massachusetts legislature has reported the introduction of a bill to deny reimbursement to any newly constructed nursing home (H4811).
MN	*A	3/82	(-)	The Minnesota legislature passed a bill which would expand the state's LTC preadmission screening program to include persons being discharged from hospitals (HF2063).
MN	*D	/81	(-)	Minnesota initiated a preadmission screening program for Medicaid recipients seeking admission to SNFs and ICFs. Alternative community care, if no more costly, is offered as an option. A waiver is being applied for regarding home and community-based services.
MS	*A	7/80	(-)	Mississippi placed a cap of 100 on the number of nursing home beds per 1,000 Medicaid recipients for which they would provide reimbursement. The resulting total number of beds was then allocated among individual facilities. The cap was in effect for one year, but in July of 1981 the federal government asked them to cease. Mississippi has appealed the ruling, and a hearing will be held in April, 1982.
NH	*P	/81	(-)	New Hampshire applied for a waiver to "focus out" from level of care reviews certain ICF patients who meet specified criteria (suffering from chronic health, functional and/or psychosocial problems; receiving proper care and proper medical record documentation; the need for their level of care validated by a bedside review). Of these patients, a 25% sample quality-of-care review would be taken per facility. This waiver was denied.
UT	*A	/81	(-)	Utah began requiring preadmission screening for recipients seeking to enter ICFs.

VA	*A	6/81	(-)	Virginia established a one-year moratorium on granting Certificates of Need (CON) for new nursing home beds.
WA	*A	12/81	(-)	The State of Washington's Utilization Review/Utilization Control staff initiated a physician recertification turn-around document to simplify the task of documenting 60-day physician recertification of the continued need for nursing home care.
WA	*A	12/81	(-)	Under federal waivers, the State of Washington has reduced the frequency of nursing home post-survey visits, extended the period of licensing/certification from one year to up to three years, and eliminated paper compliance monitoring.
WA	*A	12/81	(-)	Under federal waivers, the State of Washington has eliminated Medical Care Evaluation studies and cut back the number of Utilization Review/Utilization Control visits to SNF patients, extending the visit period up to one year.
WI	*P	2/82	(-)	Wisconsin has requested a federal waiver to modify its LTC utilization control and survey and certification processes. The modifications sought have already been validated through a four-year 1115 demonstration. The plan would reduce the paperwork burden on nursing home operators and state and federal staff, allow more flexibility in the timing of inspections and afford a more realistic policy for plans of correction. (Anticipated annual savings: $6 million.)

12. Inpatient Psychiatric Services for Individuals under 22

PA *P /82 (-) Pennsylvania is proposing to impose more restrictive criteria in utilization reviews of private (as opposed to public) psychiatric hospitals. Since private hospitals frequently treat more acute cases, the length of stay criteria would be shortened.

13. Inpatient Hospital Services for those 65 + in an Institution for Mental Disease (IMD)

PA	*P	/82	(-)	Pennsylvania is proposing to impose more restrictive criteria in utilization reviews of private (as opposed to public) psychiatric hospitals. Since private hospitals frequently treat more acute cases, the length of stay criteria would be shortened.

20. Personal Care Services

TX	*A	9/79	(+)	Texas began coverage of personal care services. They must be pre-authorized, and reassessment of need for services is required every six months.

21. Emergency Hospital Services

WA	*P/W	/82	(-)	Washington requested a freedom of choice waiver seeking to implement a $5.00 copayment for emergency hospital and outpatient hospital visits for all Medicaid recipients, except residents of institutions. HCFA disapproved this request, stating that the legislative provision referenced provided no authority to approve waivers for copayments.

22. Prescribed Drugs

AR	*A	10/81	(-)	Arkansas raised co-payment for drug prescriptions from 50¢ to $1.00.
FL	*P	4/83	(-)	It has been proposed by the Governor of Florida in his budget recommendations that a drug copayment be imposed on Medicaid recipients.
FL	*C	/82	(-)	A drug utilization review (DUR) program is presently under consideration by the Florida Medicaid Program Development Office. The therapeutically-oriented DUR program addresses the quality implications of drug therapy. The goal of therapeutic DUR is to eliminate those drug therapies which block/retard successful therapy, or induce secondary disorders with unwarranted risk to the patient as well as unnecessary and wasteful expense to the Medicaid Program.
GA	*A	11/81	(-)	Georgia has raised its copayments for prescription drugs from 50¢ per prescription to a sliding scale, according to the price of the prescription: $10.99 or less = 50¢ copayment; $11.00 - $25.99 = $1 copayment; $26.00 - $50.99 = $2 copayment; and $51.00 or more = $3 copayment.
IN	*P	1/82	(+)	The Indiana legislature reported that a bill was introduced to prohibit the imposition of a copayment on drugs.
ME	*A	2/82	(-)	The state of Maine has imposed a $.50 copayment on prescription drugs for all non-institutionalized Medicaid recipients.
MI	*P	1/82	(-)	The State of Michigan will expand its present 50¢ drug copay policy to an increased number of high price drug products.
MI	*A	11/78	(+)	Certain dietary formulas covered for recipients under 21. Subject to prior authorization.
MO	*P	1/82	(-)	The Missouri legislature reported the introduction of a bill to impose maximum allowable copayments on dental services, drugs, optometric services, eyeglasses, dentures, and hearing aids (HB1089).
NH	*P	/81	(-)	New Hampshire applied for a waiver in order to drop the 3-per-month limitation on prescription drugs and to impose a $3.50 copayment per prescription for all recipients, with the exception of nursing home residents. The waiver was denied.
NJ	*A	2/81	(-)	New Jersey adopted a recipient lock-in system for overutilizers of physician and pharmacy services.
NC	*A	3/82	(-)	North Carolina instituted recipient lock-ins for over-users of physicians' and pharmacists' services.

OR	*C	/82	(-)	Oregon is considering the imposition of copayments on drugs.
PA	*P	/82	(-)	The Pennsylvania legislature is considering a bill to impose a 50¢ copayment on drug prescriptions.
RI	*P	4/82	(-)	Rhode Island proposes to require of all Medically Needy Only recipients a drug copayment of 50¢ per prescription.
RI	*P	4/82	(-)	Rhode Island proposes that all prescriptions written for valium and other drugs falling into the Benzodiazepine classification will require an original prescription (no refills). Nursing home residents are exempt.
SD	*C	/82	(-)	South Dakota is considering increasing prescription drug copayments. They are currently 50¢ per prescription.
TX	*A	9/82	(-)	Texas will begin requiring a recipient copayment of 50¢ for each prescription.
VT	*A	2/82	(-)	Vermont instituted a copayment of $1.00 for all prescription drugs. Nursing home residents are exempt.

23. Dental Services

CA	*A	1/83	(-)	California proposes to expand prior authorization of dental services to approximately 85% of all procedures.
IA	*P	4/82	(-)	Iowa plans to increase its copayment on dental services from $1.00 to $3.00 for total covered service rendered on a given date (EPSDT and institutionalized recipients are exempt). HCFA has disapproved this plan amendment because of the exemption of institutionalized individuals, but an appeals hearing is scheduled.
MO	*P	1/82	(-)	The Missouri legislature reported the introduction of a bill to impose maximum allowable copayments on dental services, drugs, optometric services, eyeglasses, dentures, and hearing aids (HB1089).
MO	*A	11/81	(-)	Missouri established a copayment requirement on all dental services. The amount of the copayment is based on the federal schedule presented in 42 CFR 447.54 (a)(3).
NE	*P	/82	(+)	Nebraska has proposed to modify its prior authorization requirements for dental services. Any non-emergency services costing more than $100 would have to be preauthorized. Previously, services costing more than $60 required local preauthorization; those over $200, state preauthorization.

24. Dentures

MO	*P	3/82	(-)	Missouri has proposed to establish more stringent guidelines on the prior authorization of dentures.
MO	*P	1/82	(-)	The Missouri legislature reported the introduction of a bill to impose maximum allowable copayments on dental services, drugs, optometric services, eyeglasses, dentures, and hearing aids (HB1089).
MO	*A	10/81	(-)	Missouri has imposed a prior authorization requirement on all dentures.

25. Clinic Services

OR	*C	/82	(-)	Oregon is considering the imposition of copayments on visits to clinics and hospital outpatient facilities, as well as to physicians. These would require waivers from the federal government.
UT	*A	/81	(-)	Utah began requiring mental health clinics to seek prior authorization for new, unusual, or unproven procedures. These procedures are defined by the Utah State Medical Association in its relative value study. Prior authorization is also required for more than 12 individual psycho-therapy sessions and for more than three group therapy sessions per week.

26. Eyeglasses

DC	*A	2/77	(-)	The District of Columbia imposed a $2.00 copayment on eyeglasses and a 50¢ copayment on prescription drugs.
KS	*A	7/81	(-)	The State of Kansas added a $.50 copayment for eyeglasses.
KY	*A	6/81	(-)	Kentucky began requiring preauthorization for eyeglasses given to children.
MO	*P	1/82	(-)	The Missouri legislature reported the introduction of a bill to impose maximum allowable copayments on dental services, drugs, optometric services, eyeglasses, dentures, and hearing aids (HB1089).
RI	*A	/80	(+)	Rhode Island modified prior authorization requirements for optometrists' services: • Required pre-authorization for replacement of eyeglasses within one year of previous purchase of eyeglasses. • Dropped preauthorization requirement for frames costing over $8. • Standardized, for all ages, requirement for pre-authorization for perceptual visual training and visual examinations performed sooner than one year after last examination. Previous time trigger for pre-authorization was one year for those 65 and older, and two years for those under 65.

27. Optometrists' Services

IA	*P	4/82	(-)	Iowa plans to increase its copayment for optometric services from $1.00 to $2.00 for total covered service rendered on a given date (EPSDT and institutionalized recipients exempt). HCFA has disapproved this plan amendment because of the exemption of institutionalized individuals, but an appeals hearing is scheduled.
MO	*P	1/82	(-)	The Missouri legislature reported the introduction of a bill to impose maximum allowable copayments on dental services, drugs, optometric services, eyeglasses, dentures, and hearing aids (HB1089).
RI	*A	/80	(+)	Rhode Island modified prior authorization requirements for optometrists' services: • Required pre-authorization for replacement of eyeglasses within one year of previous purchase of eyeglasses. • Dropped preauthorization requirement for frames costing over $8. • Standardized, for all ages, requirement for pre-authorization for perceptual visual training and visual examinations performed sooner than one year after last examination. Previous time trigger for pre-authorization was one year for those 65 and older, and two years for those under 65.

31. Rehabilitative Services

IA	*P	4/82	(-)	Iowa plans to institute a $2.00 copayment on rehabilitative services for total covered service rendered on a given date (EPSDT and institutionalized recipients exempt). HCFA has disapproved this plan amendment because of the exemption of institutionalized individuals, but an appeals hearing is scheduled.
NJ	*A	2/82	(-)	The State of New Jersey requires prior authorization of psychiatric/psychological services in long term care facilities and boarding homes after an initial evaluation.
TX	*A	4/81	(-)	Texas changed its terminology from "Adult Day Health Services" to "Day Activities and Health Services" to better reflect the benefit. In addition, it decreased the frequency of required assessment of need for services from 90 days to six months.

32. Podiatrists' Services

IA	*P	4/82	(-)	Iowa plans to institute a $1.00 copayment on podiatrists' services for total covered service rendered on a given date (EPSDT and institutionalized recipients exempt). HCFA has disapproved this plan amendment because of the exemption of institutionalized individuals, but an appeals hearing is scheduled.
IA	*P	4/82	(-)	Iowa plans to increase its copayment from $1.00 to $2.00 for orthopedic shoes (EPSDT and institutionalized recipients exempt). HCFA has disapproved this plan amendment because of the exemption of institutionalized individuals, but an appeals hearing is scheduled.
MO	*A	11/81	(-)	Missouri imposed a variable copayment on podiatric services.

33. Chiropractors' Services

IA	*P	4/82	(-)	Iowa plans to institute a 50¢ copayment on chiropractors' services for total covered service rendered on a given date (EPSDT and institutionalized recipients exempt). HCFA has disapproved this plan amendment because of the exemption of institutionalized individuals, but an appeals hearing is scheduled.

36. Physical Therapy

AL	*A	4/81	(-)	Alabama imposed new limitations on physical therapy, covering it only by prior authorization from the Alabama Medicaid Agency and based on medical necessity. Physical therapy is covered only when given by a physician or under his direct supervision, or in a hospital outpatient setting.
IA	*P	4/82	(-)	Iowa plans to institute a 50¢ copayment on physical therapy, for total covered service rendered on a given date (EPSDT and institutionalized recipients exempt). HCFA has disapproved this plan amendment because of the exemption of institutionalized individuals, but an appeals hearing is scheduled.

37. Occupational Therapy

RI	*A	/80	(-)	Rhode Island began requiring prior authorization for occupational therapy in a hospital outpatient setting.

38. Speech, Hearing, and Language Disorders

IA	*P	4/82	(-)	Iowa plans to increase its copayment on audiologists' services from $1.00 to $2.00 for total covered service rendered on a given date (EPSDT and institutionalized recipients exempt). HCFA has disapproved this plan amendment because of the exemption of institutionalized individuals, but an appeals hearing is scheduled.
MO	*P	2/82	(-)	Missouri has proposed to conduct pre-payment reviews of all audiology claims to determine that a hearing aid evaluation form is submitted and properly completed; that a physician has examined the patient; that a hearing evaluation has been performed; that the need exists for a hearing aid; etc. Pre-payment review of all audiology claims is supported by the Audiology Subcommittee of the state's Medical Advisory Committee.
MO	*A	11/81	(-)	Missouri has imposed a copayment requirement on audiology services.

39. Prosthetic Devices

AL	*A	4/81	(-)	Alabama began requiring prior authorization for any binaural fitting of a hearing aid and for replacement of aids within one year of delivery.
IA	*P	4/82	(-)	Iowa plans to increase its copayment from $1.00 to $2.00 for orthopedic shoes (EPSDT and institutionalized recipients exempt). HCFA has disapproved this plan amendment because of the exemption of institutionalized individuals, but an appeals hearing is scheduled.
IA	*P	4/82	(-)	Iowa plans to increase its copayment from $1.00 to $3.00 for hearing aids (EPSDT and institutionalized recipients exempt). HCFA has disapproved this plan amendment because of the exemption of institutionalized individuals, but an appeals hearing is scheduled.
MI	*P	1/82	(-)	The State of Michigan is proposing to impose a $.50 copayment on each hearing aid battery provided to a recipient. Projected savings is greater than $100,000 per year.
MI	*A	1/82	(-)	Michigan implemented a copayment of $3.00 on hearing aids for Title XIX recipients 21 and older and for all general assistance recipients.
MO	*P	1/82	(-)	The Missouri legislature reported the introduction of a bill to impose maximum allowable copayments on dental services, drugs, optometric services, eyeglasses, dentures, and hearing aids (HB1089).

42. Durable Medical Equipment and Supplies

IA	*P	4/82	(-)	Iowa plans to increase its copayment from $1.00 to $2.00 on medical equipment and supplies for total covered service rendered on a given day (EPSDT and institutionalized recipients exempt). Sickroom supplies will no longer be exempted from this copayment. HCFA has disapproved this plan amendment because of the exemption of institutionalized individuals, but an appeals hearing is scheduled.
MO	*P	3/82	(-)	Missouri has proposed to perform pre-payment review of all DME claims to determine if necessary attachments are present, if a justified diagnosis is present, if the equipment should be purchased or rented, etc.

43. Transportation

CA	*P	1/82	( )	The California legislature reports introduction of two bills to eliminate prior authorization for certain non-emergency medical transportation costs. AB1427 would exempt those costs under $50.00, and AB1428 would exempt transportation to a recipient's residence or to a lower-cost facility.
CT	*P/W	3/82	(-)	Connecticut applied for a freedom of choice waiver to impose a copayment on medical transportation (taxi and livery) and to exempt frequent users of such transportation. The waiver request was disapproved by HCFA on March 2, 1982.
CT	*P	11/81	(-)	The Connecticut legislature reported that a bill had been introduced to establish a $.50 copay for taxi usage by Medicaid recipients (H9010X).
GA	*A	11/81	(-)	Georgia began requiring prior approval for taxi transportation except for specified diagnoses, physical or mental conditions.
IA	*P	4/82	(-)	Iowa plans to institute a $2.00 copayment on ambulance services (EPSDT and institutionalized recipients exempt). HCFA has disapproved this plan amendment because of the exemption of institutionalized individuals, but an appeals hearing is scheduled.
MO	*P	2/82	(-)	Missouri has proposed to conduct pre-payment reviews of all ambulance claims to ensure that only emergency ambulance claims are paid (no routine transfers); that trips beyond ten miles are justified; that the destination is a hospital; and that multiple transfers are reviewed for necessity. This option is supported by the Ambulance Subcommittee of the state's Medical Advisory Committee.
RI	*A	/80	(-)	Rhode Island began requiring prior authorization for ambulance service for nonambulatory SNF and ICF residents.

Reimbursement

III. REIMBURSEMENT

A. General

AR	*A	10/81	(-)	Arkansas froze reimbursement levels for all individual practitioners at the current payment profile rates. (Arkansas has, in the past, updated profile rates annually.)
CA	*P	3/82	(+)	The California legislature reports introduction of a bill to pay in advance counties that provide services based on county costs for the previous quarter (AB2925).
CA	*P	1/82	(-)	The California legislature reports introduction of a bill to reduce provider rates by 2% (AB7X).
CA	*A	7/82	(-)	California statutes have increased the rate of interest on provider overpayments and now also require interest to be paid on provider underpayments that are appealed.
CT	*P	2/82	(-)	The Connecticut legislature reported the introduction of a bill that would revise uniform fee schedules to reflect the amount appropriated for services (S486). This bill would apply to practitioners of the healing arts and associated services and to vendors of sickroom supplies.
CT	*P	11/81	(-)	The Connecticut legislature reported that a bill had been introduced to limit the efficiency incentive award to any provider to a maximum of 10% of savings (H9010X).
DE	*A	7/81	(-)	Delaware has implemented a temporary freeze on reimbursement levels for all goods and services, except for hospital rates. (The state normally increases reimbursement rates annually.) This freeze will remain in effect while a state Medicaid Cost Containment Committee is studying Medicaid program expenditures. The Committee will make its recommendations in March, 1982, and they will be subject to the approval of the Governor and of the Secretary of the Department of Health and Social Services.
FL	*P	7/82	(-)	Florida has proposed to modify its policy regarding Medicare Part B crossover payments. It would: • Limit Medicaid reimbursement on Medicare Part B crossover claims to procedure codes identified as Medicaid-covered items and services; • Limit Medicaid payment for Part B deductibles and coinsurance to the Medicaid maximum allowable fees for the items or services; • Restrict Medicaid reimbursement on crossover claims to those provider types eligible for enrollment as Medicaid providers; and • Apply Medicaid caps to crossover claims.

IN	*P	1/82	(-)	The Indiana legislature reported that a bill had been introduced which requires the State Department of Public Welfare to examine the need for changes in rate structure for institutional services, and to make recommendations concerning Medicaid hospital costs (SB299).
IA	*A	4/82	(-)	Iowa imposed a 2.5% reduction for all reimbursement to Medicaid providers except hospitals, intermediate care facilities, intermediate care facilities for the mentally retarded, mental health institutes, drug ingredient costs, and non-ambulance medical transportation reimbursed directly to the recipient.
KS	*P	/82	(-)	The State of Kansas proposes to determine reimbursement on a fee-for-service basis for all non-institutional services with the exception of pharmacy. Fees will be on an established base rate related to billed charges or cost report data.
KY	*P	1/82	(-)	The Kentucky legislature reported that a bill has been introduced to require that specific dollar amounts for each optional service be budgeted and appropriated (S129).
KY	*P	/82	( )	Kentucky proposes to modify the prevailing charge for services to reflect statewide patterns rather than existing patterns with 16 separate medical areas. It would establish the Title XVIII, Part B aggregate prevailing charge for services rather than the Medicare "reasonable" charge criteria.
ME	*A	1/82	(-)	The Maine legislature passed a law requiring an annual review of all provider fee schedules. This review must be presented both to the appropriate legislative committees and to the Governor's office prior to his submission of a budget to the legislature.
MN	*P	2/82	( )	The Minnesota legislature reported the introduction of a bill to require that providers cannot deny care because of reimbursement limits (SF1880).
MN	*P	2/82	(-)	The Minnesota legislature enacted a bill to limit reimbursement increases to 10% for LTC facilities and 8% for all other providers except HMOs (HF2123).
MS	*P	2/82	(-)	The Mississippi legislature reports the introduction of a bill to authorize the state to discontinue services or reduce reimbursement if federal funding is cut or eliminated (HB233).
MS	*A	/81	(-)	Mississippi raised to $76 million the amount of state funds which can be spent annually for its Medicaid program. By law, if expenditures exceed this amount, the state must terminate the payment of services through the program.
NY	*P	1/82	( )	The New York legislature reports introduction of a bill to revise reimbursement to hospitals, nursing homes, and alternate level of care services. The bill would reduce institutional reimbursement by the allocated share of the full reduction in federal funding (S7838, A9688).

NC	*A	12/81	(-)	As of December, 1981 the North Carolina legislature froze reimbursement rates for all noninstitutional providers at the level in effect in April, 1981. The law extends the freeze through June, 1983; but it could be reconsidered when the legislature reconvenes in June, 1982.
OR	*A	10/82	(-)	Oregon delayed, for all practitioners, the annual increase in the maximum allowable fees from July (the usual date of the increase) to October, 1981. The state also reduced the increase in rates from the proposed 7% to 5%.
OR	*P	/82	(-)	The Oregon legislature passed a law which expands the definition of Medical Assistance to include payments for insurance and other contractual arrangements and money paid to the recipient for the purchase of medical care (SB 889). However, the Medicaid agency has not as of yet implemented it.
RI	*P	2/82	(-)	The Rhode Island legislature reports introduction of a bill to limit provider fee-for-service increases to 5% (S7295).
SC	*P	7/82	(-)	South Carolina is planning to adopt fee schedules for all non-institutional services for which fee schedules are not already in place.
SC	*A	7/81	(-)	South Carolina froze reimbursement levels for non-institutional services, declining to raise them as is normally done on July 1 of each year.
UT	*P	1/82	(-)	The Utah state legislature has introduced a bill which provides that the state is not required to pay for Medicaid services when funds are unavailable or have not been appropriated (HB78).
WA	*P	7/82	(+)	The State of Washington is proposing to delay for seven months scheduled increases in the wage-related components of vendor rates. After the seven-month delay, wage-related increases will be limited to 7%.

1. Inpatient Hospital Services

AL	*A	7/81	(-)	Alabama revised hospital reimbursement by paying hospitals prospectively, based on historical data, and by paying reasonable cost of inpatient hospital services under methods and standards developed by the state and approved by the Regional Medicaid Director before implementation.
CA	*A	1/82	(-)	The California Budget Act of 1981 limits cost of living adjustments for hospital inpatient discharges to 6% for state fiscal year 1981-82.
CT	*P	2/82	(+)	The Connecticut legislature reported the introduction of a bill to set up appeals procedures for hospital rates to conform to federal rules (H5391).
CT	*P	11/81	(-)	The Connecticut legislature reported that a bill had been introduced to reimburse hospitals at the average daily convalescent hospital rate for stays not medically required (H9010X).
FL	*A	7/81	(+)	Florida implemented a new prospective reimbursement system on July 1, 1981.
GA	*A	11/81	(-)	Georgia modified its hospital reimbursement methodology. As hospitals started their fiscal year on or after January 1, 1982, the State:

- Eliminated the allowance for change in medical technology (intensity factor).
- Reduced the group limit to 100% of the group mean for calculations of incentives.
- Eliminated the special allowance for price level depreciation (Growth and Development Allowance).

IL	*A	1/82	(-)	The State of Illinois established an alternative reimbursement methodology for hospital inpatient, outpatient, and clinic services, effective retroactively to October 1, 1981. To establish reimbursement rates for these services, the state first made an estimate of the utilization levels for these services for each hospital. After hospitals were given an opportunity to revise these estimates, each hospital's fiscal year 1979 cost per unit of service was updated to January 1, 1981 using a hospital inflation rate developed by Data Resources, Inc. (DRI). The DRI updating factors ranged from 29.7% for hospitals with fiscal years ending in January 1979, to 20.1% for hospitals with fiscal years ending in December 1979. The state then calculated expected spending for hospital services for October 1 through June 30 by multiplying each hospital's updated DRI figure by its estimated utilization and totalling the amounts for all hospitals. Because the DRI updated figures exceeded available funds, the figures were then reduced 14.27% for all hospitals. However, in

order to provide special relief to hospitals serving a disproportionately high volume of Medicaid patients, the adjusted DRI figures were increased by an amount equal to 3% of the reduction for each percent of Medicaid utilization between 25% and 35% Medicaid, plus 1% for each 1% over 35% Medicaid. (For example, a hospital with 15% Medicaid utilization had its DRI figure reduced by 14.27%; a hospital with 35% Medicaid utilization had its DRI figure reduced by 10.60%; and a hospital with 50% Medicaid utilization had its DRI figure reduced by 8.77%.) If the final rate, calculated as described above, is less than or equal to a hospital's current rate, the hospital will be paid at this calculated rate for services rendered after September 30, 1981, and payable from the fiscal year 1982 appropriation. If a hospital's current payment rate is less than this calculated rate, the hospital will be paid at its current rate.

New hospitals or hospitals that have significantly restructured since their fiscal year 1979 may notify the state that they have restructured, submit supporting documentation (such as certificate of need) and request a rate review. These hospitals may have artificially low rates because the restructuring has not been taken into account by this updating methodology.

In addition to the above adjustments, hospitals that have a high percentage of government payors and that may suffer extreme financial hardship as a result of this rate methodology may request special consideration for potential, severe cash flow problems. To qualify, at least 65% of the hospital's total inpatient days must be reimbursed under Medicare, Medicaid, general assistance and aid to the medically indigent and at least 20% of the total inpatient days must be reimbursed by Medicaid. The hospital must submit its most recent audited financial statement and any other financial and legal documents which would establish that the hospital has insufficient funds to meet its cash flow requirements, including a cash flow statement for July 1, 1981 through June 30, 1982. A $6.5 million pool has been set aside to assist these hospitals, with the allocation of this amount among qualifying hospitals determined by a panel of hospital fiscal experts.

IL	*A	1/82	(+)	The State of Illinois, as part of its revised hospital reimbursement methodology (see above) removed the reimbursement limits on state-funded general assistance and medically indigent hospital services which were set in July, 1981 (see earlier entry).
IN	*P	1/82	(-)	The Indiana legislature reported that a bill had been introduced which requires the State Department of Public Welfare to examine the need for changes in rate structure for institutional services, and to make recommendations concerning Medicaid hospital costs (SB299).
IA	*A	1/82	(-)	Iowa reduced reimbursement to the maximum SNF or ICF payment rate for recipients in hospitals when it is determined that they do not require acute hospital care.

IA	*A	4/82	(-)	Iowa limited reimbursement for inpatient hospital care to the 50th percentile of length of stay as indicated for recipient's diagnosis in Length of Stay in PAS Hospitals. Provision will be made for payment of longer stays in exceptional cases.
KS	*A	12/81	(-)	The State of Kansas has limited reimbursement for hospital room charges to the least expensive available multiple accommodation.
ME	*A	1/82	(-)	Maine modified its method of reimbursing for hospital services provided to inpatients awaiting transfer to a SNF or ICF. Payment for these administratively necessary days will be set at the statewide average rate for SNF or ICF care, except that payment shall not be lower for hospitals which have no excess of beds.
MA	*P	2/82	(-)	Massachusetts has proposed a reduction in payments to chronic care hospitals to reflect the level of care actually being received. Patients at a less than chronic care hospital level of care would be reimbursed at an institution-specific rate commensurate with the resources needed to care for a patient at that level of care.
MA	*P	1/82	(-)	The Massachusetts legislature reported that a bill has been introduced to limit reimbursement for intensive care services to 3 times the cost of the lowest priced bed (H493).
MA	*P	/82	(-)	Massachusetts has proposed to reimburse administrative days in acute hospitals at a flat rate of $70 for a SNF-level patient and at a rate estimated to be $64 for an ICF-level patient. This dual administrative day rate structure, if adopted, would supersede the previous payment of $70 for all administrative day patients regardless of the level of care.
MI	*A	10/81	(-)	The State of Michigan revised the prospective hospital reimbursement system it had established in January, 1980, by extending the base cost period from one to three years. Reasonable costs are now the lesser of current year allowable costs or the updated average of included costs from a three-year base period, updated by the HCI, plus excluded costs from the current year. Allowable costs are determined in accordance with the Medicare Principles of Reimbursement. Included costs are defined as the average of allowable costs, less excluded costs (capital-related and certain other costs) from the three-year base period. The hospital cost index, which is intended to reflect the rate of increase in costs that will be incurred by a Michigan hospital, contains an inflation component, a factor for volume changes and an intensity factor for expected changes in intensity (the intensity factor has been reduced to zero percent). Hospitals have their base period included costs rebased on a three-year cycle.

MN	*P	/81	(-)	Minnesota has proposed to implement a prospective reimbursement system for inpatient hospital care.
MS	*A	7/81	(-)	Mississippi implemented a prospective reimbursement system for inpatient hospital services. Rates are computed for the following year, and there is no retrospective adjustment. This plan also places hospitals in five groupings, according to bed size, and reimbursement is limited to 80 percent of each group's average daily rates. The Mississippi Hospital Association sought an injunction against the plan in federal district court, stating that proper regulatory procedures were not followed, calling the classification of hospitals by bed-size alone "irrational," challenging the imposition of occupancy rate standards and questioning whether reimbursement was at a "reasonable cost" level. The courts refused to enjoin the state, and the Hospital Association appealed to the Fifth Circuit Court. No ruling was made prior to the enactment of the Omnibus Reconciliation Act, which rendered the case moot. The Hospital Association has filed a new suit with the District Court, which will be heard in August, 1982.
MO	*P	7/82	(-)	Missouri has proposed to revise is inpatient hospital reimbursement plan to include a utilization factor and to use a more conservative estimate of inflation such as the Consumer Price Index instead of the Market Basket.
MO	*P	1/82	(-)	The Missouri legislature reported the introduction of a bill to revise its cost-related reimbursement systems for inpatient hospital and nursing home services (HB1089).
NE	*C	/82	(-)	Nebraska is considering the development of a prospective reimbursement system for inpatient hospital services.
NV	*P	3/82	(-)	Nevada has proposed to reimburse individual hospitals for administratively necessary days at the statewide average SNF or ICF rate, as appropriate.
NH	*A	/82	(-)	New Hampshire implemented a prospective reimbursement system for inpatient hospital services.
NY	*D	11/79	(-)	The State of New York has received waivers to test in the New York City communities of Bedford-Stuyvesant/Crown Heights a new approach to ambulatory care reimbursement for hospitals and free-standing facilities designed to: • increase efficiency; • assure access for Medicaid and medically-indigent patients; • assure financial stability; and • link financing and planning. The project sets out to reduce excess acute beds, regionalize costly specialty/tertiary inpatient acute care among hospitals in the area, and improve access to outpatient and ambulatory settings. Improvement in overall efficiency of management will be pursued.

NC	*A	11/81	(-)	North Carolina implemented a prospective reimbursement system for inpatient hospital services.
OH	*P	/82	(-)	Ohio is considering reimbursement of inpatient hospital services on a prospective basis.
PA	*P	/82	(-)	The Governor of Pennsylvania's budget proposal, considered likely to pass, would mandate an across-the-board 8% limit on the increase in hospital reimbursement by the Medicaid program. In the initial stage, the rates paid per facility on February 9, 1982 would be carried forward, increased by a specified inflation factor, through June 30. The June 30th rate for each facility would then serve as a base rate, and a maximum increase of 8% would be allowed.
VT	*A	7/81	(-)	Vermont reduced reimbursement for inpatient hospital services from 100 to 90 percent of the Medicaid allowed amount.
VA	*C	/82	(-)	Virginia is considering making substantial changes in its hospital reimbursement methodology.
WV	*A	3/82	( )	West Virginia reduced interim payments for inpatient hospital services by 15%, through June 30, 1982.
WI	*A	12/81	(-)	Wisconsin dropped its exclusion of hospitals with an occupancy rate of 80% or more during the previous year from its policy of paying for hospital administrative days at the average adjusted SNF rate.

2. Outpatient Hospital Services

CT	*P	11/81	(-)	The Connecticut legislature reported that a bill had been introduced to reimburse hospital outpatient clinics and emergency rooms at a rate not to exceed 150% of the combined average fee of a general practitioner and specialist office visit (H9010X).
DC	*P	5/82	(-)	The District of Columbia is considering a proposal to place a limitation of 109% of audited FY80 costs on reimbursement levels for hospital outpatient and emergency room services.
FL	*A	1/82	(-)	The State of Florida changed to a prospective reimbursement system for outpatient hospital services.
FL	*P	1/82	( )	The Florida legislature reported that bills had been introduced to extend a pilot project, initiated in October, 1978, which had raised the cap on outpatient hospital services per year from $100 to $500 in exchange for contributions by Florida counties of a percentage of their indigent care incomes (HB546 and S279). There are also discussions about dropping the project and lowering the $500 cap to the pre-1978 $100 level.
GA	*A	11/81	(-)	Georgia began reimbursing Emergency Room visits for minor and chronic illnesses at a flat rate of $10 per visit. This is an all-inclusive rate.
IL	*A	1/82	(+)	The State of Illinois, as part of its revised hospital reimbursement approach (see III1) rescinded the changes in its OPD and clinic reimbursement methodologies which were adopted in July, 1981 (see earlier entry).
IL	*A	1/82	(-)	The State of Illinois revised its reimbursement methodology for hospital inpatient, outpatient, and clinic services. See Section III1 for details.
MA	*P	1/82	( )	The Massachusetts legislature reported that a resolution has been introduced to require the Department of Public Welfare to study reimbursement alternatives for hospital outpatient services (S635).
MN	*P	/81	(-)	Minnesota is considering reimbursing all outpatient hospital services, except emergencies, on the same basis as services provided in other settings, i.e., physician offices.
NC	*A	12/81	(-)	North Carolina limited outpatient hospital services reimbursement to 80% of allowable costs. Payment was previously at 90% of allowable costs.
OH	*P	/82	(-)	Ohio is considering reimbursement of outpatient hospital services on a fee-for-service basis.

RI	*P	4/82	(-)	Rhode Island proposes to reduce reimbursement levels for hospital outpatient services from 100 percent to 90 percent of the reimbursable cost of such services as determined through application of the principles of Rhode Island's Prospective Hospital Reimbursement System. This rate of reimbursement will be applied to all hospital clinic and emergency room visits, laboratory tests, x-rays and other services provided in the hospital outpatient department. However, it will not apply to the costs associated with provision of ambulatory surgery in a hospital outpatient department.
SC	*A	3/82	(-)	South Carolina lowered its reimbursement levels for hospital outpatient services by 46 percent, across the board. The state had originally proposed to alter reimbursement for these services by paying physician rates for services comparable to those delivered in physicians' offices. However, the hospital association took the state to court over this proposal as well as one to lower the hospital day limitation to 12 days per year. The state won the court suit. However, it negotiated with the hospital association and agreed to adopt the 46 percent reduction in lieu of reimbursement at physician rates.
WI	*A	12/81	(-)	Wisconsin broadened, to apply to all outpatient services, its policy of limiting reimbursement for OPD lab and x-ray services to rates comparable to that paid to independent providers of such services.

3. Rural Health Clinic Services

KY IHPP	*A III3	11/81 N	( ) *2	Kentucky began defining "provider-based rural health clinics" and "visit" and mandating Medicaid reimbursement for reimbursable charges based on Medicare methodology. For Medicaid services not covered by Medicare, the interim rate is based on prior year data or, for new facilities, approximate costs with six-month adjustments for the first year.

4. Laboratory and X-Ray

CA *A 8/81 (-) California has adopted a policy which stipulates that when three or more lab tests are performed together on automated laboratory equipment, they are to be billed and reimbursed as an automated test.

GA *A 11/81 (-) Georgia limited the proposed increase in the maximum allowable payments to independent laboratories to no more than 3% above current rates.

MI *P 4/82 (-) The State of Michigan is considering the volume purchase of hearing aids, laboratory services, and drugs.

MI *A 4/82 (-) Michigan reduced by 10 percent its fee screens for the following lab tests:

Code	Description
6650	Thyroxine, free, by analysis
6661	Tri-iodo-thyronine
6700	Thyroid stimulating hormone
6850	Thyroxine binding globulin
8227	T-3 uptake
8517	Immunodiffusion, quantitative, IGA, etc.
8887	Culture, aerobic, other than blood and urine, definitive
8888	Culture, urine, definitive, with colony count

Reimbursement levels were reduced by twenty percent for the following tests: Vitamin B-12 (6750) and Folic acid (folate) (6751).

NJ *C /82 (-) New Jersey is considering competitive bidding for selecting providers of independent laboratory services.

WA *C 7/82 ( ) The State of Washington is considering volume purchasing arrangements for laboratory tests, or, as an alternative, the establishment of payment for common lab procedures at the automated rate.

5. Skilled Nursing Facility (SNF) for Individuals 21 and older

AL	*P	2/82	( )	The Alabama legislature reported the introduction of a bill to create a Pediatric and Long Term Care Commission which would be responsible for establishing Medicaid nursing home reimbursement rates (S.58).
AR	*A	7/81	(-)	Arkansas changed its methodology of nursing home reimbursement by moving from a facility rate to a strict class rate. It pays at the 80th percentile for each of six classes of nursing homes. An incentive factor was eliminated.
AR	*A	/78	(-)	Arkansas implemented the following changes in the state's nursing home reimbursement methodology: • established rate ceilings; • set reimbursement according to peer groupings; • tied reimbursement rates to grades of patient disability; • indexed reimbursement rate to economic trend factors; and • began imputing a useful lifetime of 40 years to nursing home facilities.
CA	*P	1/82	(-)	California proposes to increase paid leave days for nursing home patients in certain programs for the mentally disordered from 18 to 30 days per year, separately define "bed holds" as days when patients are in acute care facilities, and reduce reimbursement for all leaves and "bed holds" by $2.31 per day.
CO	*P	2/82	(+)	The Colorado legislature reports introduction of a bill to share with nursing homes the difference between reasonable and actual administrative costs (HB1250).
CO	*A	/81	( )	The Colorado agency has enacted a program which directly funds community mental health centers for psychiatric services provided to nursing home residents.
CO	*A	/81	(-)	Colorado Medicaid implemented a new law (SB38) which included a local Medicaid match requirement for nursing home care, and a decrease in the local Social Services (Title XX) match requirement for non-institutional (e.g., homemaker) services.
CT	*P	7/82	(-)	Connecticut has proposed regulations to alter the reimbursement system for nursing homes by capping rates at 150% of the statewide median rate. Anticipated savings will be utilized to pay extra incentive allowances where nursing homes fall below the median state-wide rate.

FL	*P	7/82	(-)	Florida has proposed that nursing homes participating in Medicaid must be certified for Medicare as well, thus allowing the state to capture the Medicare payments currently being by-passed due to certain facilities being Title XIX-certified only.
FL	*P	2/82	(-)	The Florida legislature reported that a bill had been introduced to create a new reimbursement plan for long term care facilities based upon: 1) single level of payment; 2) geographic and size classifications; and 3) incentives for efficiency and quality (HB742).
GA	*A	11/81	(-)	Georgia decreased the overall growth allowance for nursing homes from the current rate of 12.6% to 4.5%, and eliminated the usual rate adjustment at the end of the calendar year.
HI	*C	7/82	(-)	Hawaii is considering the development of a prospective reimbursement system for nursing homes. (Projected Savings: $4 million.) An alternative also being considered is the placement of a ten percent cap on cost increases, per facility.
ID	*A	1/82	(-)	The State of Idaho has implemented a new nursing home reimbursement system which has the following characteristics: • it classes facilities by type (i.e., hospital-based, freestanding SNF/ICF, freestanding ICF, or ICF-MR); • it places prospective caps on maximum payments by class of facility; • it pays providers who are below the cap an "efficiency incentive"; and • it recaptures depreciation paid providers if they sell the home for more than the historical cost plus depreciation paid.
IA	*A	4/82	(-)	Iowa reduced SNF reimbursement to the maximum ICF or RCF (Residential Care Facility) payment rate for resident recipients when it is determined they do not require the SNF level of care. A residential care facility is a facility providing a lower level of care which is reimbursed with state funds only, since it is not eligible for Title XIX funds.
KY	*A	4/81	( )	Kentucky altered its policy on the gain on sale of nursing home facilities from 8 1/3 years to 12 1/2 years in determining allowable costs of transactions.
KY	*A	/81	(-)	Kentucky eliminated direct reimbursement for mental health services for residents in nursing homes. These must be provided through the facilities.
MI	*A	1/82	(-)	Michigan reduced the maximum profit factor for proprietary SNFs from $1.25 per patient day to $1.00.
MN	*A	3/82	(-)	The Minnesota legislature enacted a bill to require annual audits of some nursing homes, at least 5% of which would be randomly selected and 20% selected by various factors (SF1605).

MO	*P	1/82	(-)	The Missouri legislature reported the introduction of a bill to revise its cost-related reimbursement systems for inpatient hospital and nursing home services (HB1089).
MO	*P	1/82	(-)	The Missouri legislature reported the introduction of a bill to limit nursing home reimbursement to the provider's per diem times a percentage of between 75% and 90% of licensed bed capacity and to limit reimbursement for new facilities to 110% of the original CON estimate (HB1953).
NE	*P	3/82	(-)	Nebraska has proposed to implement a prospective reimbursement system for nursing home facilities.
NV	*A	1/82	(-)	Nevada has advised its LTC facilities that the prospective cost areas (administration and housekeeping) will not be increased in CY 82.
NV	*C/D	/82	(-)	Nevada is considering a pilot project involving capitation payments to LTC facilities for all physician services provided to LTC patients.
NV	*C/D	/82	(-)	Nevada is considering a demonstration project to provide a capitation payment to LTC facilities for prescription drugs provided to LTC patients.
NH	*P	/81	(-)	New Hampshire applied for a waiver to reimburse for services to nursing home patients through direct provider payments for covered medically necessary services rather than applying medical costs in excess of the established limits to the cost of care and thus adjusting the reimbursement to the nursing home. The waiver was denied.
NJ	*P	2/82	( )	The New Jersey legislature reported the introduction of a bill to create a new State authority to assist in finding sources of capital for nursing homes that allocate at least 75% of their beds to Medicaid patients (A707).
NJ	*A	9/81	(-)	Reduced nursing home screens for reimbursement purposes.
OK	*A	1/81	(+)	Oklahoma raised per diem rates for SNF services.
PA	*P	7/82	(-)	Pennsylvania is proposing to cease, as of July, 1982, payment to nursing homes for depreciation and interest costs unless the institutions have received Certificate of Need (CON) prior to July, 1982.
PA	*A	2/80	(+)	Pennsylvania raised reimbursement ceilings for ICFs and SNFs.
RI	*A	1/82	(-)	Rhode Island modified its nursing home reimbursement methodology, principally by dropping the Consumer Price Index (CPI) as the economic index used in computing inflation-related increases in reimbursement levels. In its place, it adopted HCFA's National Nursing Home Input Price Index, which is more reflective of nursing home costs. In addition, rate increases tied to economic trends will no longer apply to cost centers for interest and depreciation.

SC	*A	7/82	(-)	South Carolina is in a transitional phase, moving from the use of the Consumer Price Index to a local index (designed by the South Carolina Division of Research and Statistical Services, Budget Control Board) in determination of the inflation factor used in computing nursing home reimbursement rates. The transition will be completed in July 1, 1982.
SC	*A	11/78	(-)	Because of an excess of SNF beds, South Carolina allowed dual licensure of some SNF's so that they could also provide ICF services. Reimbursement for these facilities is made at a composite rate, based upon the total cost of itemized patient days.
SD	*P	1/82	( )	The South Dakota legislature reports that a bill has been introduced to limit private pay nursing home rates to 110% of Medicaid rates for homes participating in Medicaid (SB 218).
VA	*C	/82	(-)	Virginia is considering making substantial changes in its nursing home reimbursement methodology.
VA	*A	7/81	(-)	The State of Virginia increased the minimum occupancy requirement of its prospective reimbursement system from 85% to 95% for certified nursing homes (distinct parts) over 30 beds. Certified units of 30 beds or less, e.g., small SNF distinct parts, will maintain the previous 85% occupancy requirement.
VA	*A	7/81	(-)	The State of Virginia made the following changes in the manner in which it reimburses for capital costs: (1) It reduced its construction cost limit for new facilities and bed addition to a reimbursable maximum of $22,965 per bed if 3 independent bids are obtained and the provider accepts the most prudent bid except where the nursing home operator or related party serves as the contractor. Bids must be obtained in an open competitive manner and full disclosure will be required by the Program prior to initial rate setting. Operator/contractors and related party's reimbursable costs will continue to be limited to the lower of the effective Construction Cost Limit or allowable cost as defined by Medicare principles of reimbursement. (2) The reimbursable Construction Cost Limit will be adjusted annually on a calendar year basis using Dodge Construction Systems Costs for a 385 sq. ft. per bed "high average" cost facility. The above limit will be adjusted on January 1, 1982 and will apply to all new nursing home beds licensed on or after October 1, 1982. The limit will be adjusted annually thereafter using Dodge Construction Systems Costs. The current limit will remain in effect until October 1, 1982. (3) All providers must have an approved Certificate of Need prior to becoming enrolled as Medicaid providers. In the event of a sale of a nursing home, the purchaser must have a valid Certificate of Public Need in order to receive Program reimbursement. (4) Reimbursement will not be made for costs in excess of those approved by the State Health Commissioner under the Certificate of Public Need law and regulations.

VA *A 7/81 (-) The State of Virginia also made changes in its reimbursement policies affecting the financing of nursing home costs. The state will continue its policy to disallow cost increases due to the refinancing of existing debt except in cases of expansion or renovation when required by the mortgage holder. Refinancing will be permitted in cases where refinancing would produce a lower rate and result in cost savings.

Financing for all new facilities and expansions initially licensed after September 30, 1982, for all major renovations which require a Certificate of Public Need completed on or after September 30, 1982, and for all purchases occurring on or after June 30, 1981 will be subject to the following limitations:

(a) Interest expenses will be limited to not more than rates authorized by the Virginia Housing Development Authority on the dates of commitment for construction financing and closing of the permanent financing. Where Bond Issues are used as the source of permanent financing, the date of sale will be considered as the date of closing.

(b) The aggregate of the following financing costs will be limited to 5% of the effective construction cost limit:

Examination fees
Guarantee fees
Financing expenses (Service fees, placement fees, feasibility studies, etc.)
Underwriters' discounts
Loan points

(c) The aggregate of the following financing costs will be limited to 2% of the effective construction cost limit:

Legal fees
Organizational costs
Cost certification fees
Title and recording costs
Printing and engraving costs
Rating agency fees

(d) In compliance with Medicare principles of reimbursement the Program will continue to disallow costs associated with mortgage life insurance premiums and debt reserve funds.

VA *A 7/81 (-) The State of Virginia also made the following changes in its policies concerning the purchase of existing facilities:

1. Appraisals must now include a breakdown by cost category for a minimum of the following items:

a – Building
b – Fixed Equipment
c – Moveable Equipment
d – Land

2. The estimated remaining useful economic life of the three categories of building, fixed equipment, and moveable equipment must be included in the appraisal. This information will be utilized to compute depreciation schedules.

3. The seller of the facility shall make a retrospective settlement with the Program in instances where a gain was made on disposition. The Program will recapture the total amount of depreciation paid to the provider by the Program for the period of participation in the Program in the event the gain equals or exceeds total depreciation expenses. No depreciation adjustment will be made in the event of a loss or abandonment. A final cost report and refund of depreciation expense, where applicable, will be due within 90 days from the date of the consummation of the sale.

VA *A 7/81 (-) The State of Virginia made the following changes in its nursing home reimbursement policies:

1. With respect to the cost of living increase rate, the add-on to the rate of change of the Consumer Price Index (CPI-U) will be reduced from 2% to 1% for those providers under prospective reimbursement. Effective for fiscal periods beginning on or after July 1, 1982, the add-on will be eliminated entirely and the cost of living rate will be based strictly on the percentage change in the average CPI-U.

2. The operating cost limit for providers under prospective reimbursement was reduced from 135% to 125% of the per diem statewide average operating cost.

3. Costs claimed for legal fees are now limited to fees for services rendered and must be related to patient care as defined by Medicare principles of reimbursement. Documentation for legal costs must be available at the time of audit. Retainer fees are considered allowable.

   Leases approved prior to August 18, 1975, are to have the terms of those leases honored for reimbursement throughout the duration of the lease. Renewals and extensions to these leases will be honored for reimbursement purposes only when the dollar amount negotiated at the time of renewal does not exceed the amount in effect at the termination date of the existing lease. No escalation clauses will be approved.

4. Effective for cost reports filed after July 1, 1981, a new facility shall have an interim rate determined using a pro forma cost report or detailed budget prepared by the provider which presents its anticipated allowable cost for the first cost report period of

participation. This rate shall be subject to retroactive adjustment to actual allowable Program cost following the review and audit of the initial cost report.

5. A new facility's costs are subject to retroactive adjustment to actual allowable Program costs for the first and second cost reporting periods of operation.

6. A new facility shall have a prospective operating cost rate set for its third cost reporting period. During the third period it will be eligible to participate in the cost efficiency and cost savings incentives.

7. The per diem operating cost rate for a new facility shall not exceed 140% of the applicable statewide per diem average operating cost in each of its first two cost reporting periods. During the first two cost reporting periods, the occupancy limits stated elsewhere will not apply.

WA	*C	/82	(-)	The Washington legislature is considering legislation which would reimburse nursing homes on the basis of cost centers: patient care, food, administration and operation, and property, plus a return on equity. The bill would permit a 20% shift between cost centers excluding property (SB3765).
WA	*P	7/82	(-)	The State of Washington is pursuing capitation reimbursement alternatives for prescriptions provided to nursing home patients.
WA	*A	7/82	(-)	The State of Washington will implement various rate cost-savings initiatives in the nursing home program: a) cut back scheduled increase for patient care enhancement; b) cut in half reimbursement for specialty consultants; c) cut back scheduled inflation increase; d) pay only for nurse aide training actually provided.
WA	*A	11/81	(-)	The Washington State legislature proposed a bill to reduce nursing home reimbursement rates for various cost centers and to increase collection of overpayments to nursing homes (SHB760).
WI	*A	12/81	(-)	Wisconsin established a policy of fining an ICF or SNF between $10 and $100 for each day that it refuses to recover Medicare costs or obtain Medicare certification.
WI	*A	5/81	(-)	Wisconsin limited its reimbursement for reserve bed days to only those LTC facilities with occupancy rates of 93% or more.
WI	*A	5/81	(-)	Wisconsin incorporated funding of incontinency supplies into its LTC facility per diem rate.

6. Home Health Services

KY	*A	4/81	( )	Kentucky established home health service reimbursement rates based on Medicare data and methodology with a year-end adjustment to actual cost.
MI	*C	/82	(-)	The State of Michigan is giving consideration to placing reimbursement limits on home health services, departing from current policy of paying percentage of charges.
MI	*A	7/81	(+)	The State of Michigan began allowing for the first time enrollment of proprietary home health agencies.
MS	*A	7/81	(-)	Mississippi began reimbursing for home health care on a prospective basis related to Medicare reimbursement principles. The previous method of reimbursement was retrospective according to Medicare standards, the lesser of cost or charges.
MO	*P	2/82	(-)	Missouri has proposed to recover over-payments through home health cost settlements.
NV	*P	3/82	(-)	Nevada proposes to change its payment methodology for home health agency services from Medicare type cost reimbursement to a fixed fee schedule for each service.
PA	*P	/82	(+)	Pennsylvania proposes to increase its fees for home health agency services, in an effort to encourage home health care as an alternative to institutional long term care.

7. Physician Services

CO	*A	/81	(-)	The Colorado legislature passed a bill (SB525) which requires the Medicaid agency to consider providing reimbursement incentives to physicians for decreasing recipient utilization of inpatient hospital services.
GA	*A	11/81	(-)	Georgia limited the proposed increase in the maximum allowable payments to physicians to no more than 3% above current rates.
GA	*A	11/81	(-)	Georgia began providing incentive payments to physicians for performing approved procedures on an in-office or outpatient basis. It developed a list of specific surgical procedures for which incentive payments may be offered when performed on an outpatient basis.
GA	*A	11/81	(-)	Georgia limited reimbursement to physicians for injectable drugs administered in the office to no more than the generic cost of the drug.
HI	*C	7/82	(-)	Hawaii is considering physician reimbursement by capitation, through HMOs, rather than by fee-for-service. (Projected savings: $30 million. In addition, there is a projected savings of $2 million in fiscal intermediary costs, if this proposal is implemented.) An alternate method of reducing physician costs, also being considered, is the adoption of the CPT-4 procedural code system, with fixed dollar amounts for each procedure.
KS	*P	2/82	(-)	The State of Kansas will no longer pay for laboratory handling charges.
KS	*A	11/81	(+)	Kansas increased reimbursement for 137 surgical and diagnostic procedures to 75th percentile of 1981 Medicare rates if procedures done on an ambulatory basis.
KY	*P	/82	( )	Kentucky proposed to derive physician reimbursement based on prevailing charges from overall patterns within the state, rather than by specific medical service area. The aggregate prevailing charge established under Part B, Title XVIII on a statewide basis would be used, rather than the reasonable physician's charge as recognized by Part B, Title XVIII.
KY	*A	4/81	(-)	Kentucky modified its physician reimbursement polices to provide that the upper limit of reimbursement to new physicians cannot exceed the 50th percentile of the range of charges for covered procedures. Reimbursement for physicians' services to hospital inpatients was reduced from 70% to 60% of allowable charges in excess of the first $50 per procedure, which is reimbursed at 100%.
MD	*A	7/80	(+)	Maryland implemented, for physician services, a variable fee schedule based on the Standard American Medical Association Current Procedural Terminology-Fourth Edition (CPT-4) classification.

MI	*C	7/82	(-)	The State of Michigan has proposed to pilot a primary care physician sponsor project in Wayne County. Most recipients will be required to designate a physician sponsor to act as case manager. Participating physicians will be paid on a fee-for-service basis, plus a monthly per-recipient case-management fee.
MN	*A	2/82	( )	The Minnesota legislature enacted a bill to set the capitation rate for HMOs at 85% of average monthly per capita fee-for-service payments for non-HMO recipients (HF2123).
MO	*P	2/82	(-)	Missouri has proposed to increase fees for evening office visits (thereby decreasing cost and use of the hospital emergency room).
MO	*P	2/82	(-)	Missouri has proposed to increase fees for deliveries performed in the office (thereby decreasing cost and use of the inpatient/outpatient hospital).
NE	*A	3/82	(-)	Nebraska has established its own system for establishing usual, customary, and prevailing Medicaid physician charges. This essentially replaces the state's previous physician fee schedules.
NV	*C/D	/82	(-)	Nevada is considering a pilot project involving capitation payments to LTC facilities for all physician services provided to LTC patients.
NY	*D	/81	(+)	New York implemented a demonstration project in Suffolk County whose purpose is to demonstrate various physician reimbursement mechanisms including physician lock-in, case management, and fee-for-service, and to compare the various methods of reimbursement in terms of efficiency and cost-effectiveness.
OR	*A	3/82	(-)	Oregon reduced fees for certain physician office visits.
OR	*A	2/82	(-)	Oregon reduced surgical fees and anesthetist reimbursement by 10%.
PA	*P	10/82	(+)	Pennsylvania plans to revise its physician fee schedule. It will increase the maximum fees and will make the fees for various services more compatible with each other.
PA	*A	11/81	(+)	Pennsylvania increased physicians' office visit fees from $8.00 to $11.00.
SC	*A	2/82	(-)	South Carolina reduced physician reimbursement by ten percent. It is calculated on a usual and customary or prevailing rate basis, and reimbursement is now at 90 percent of that amount.
WA	*A	1/82	(+)	The State of Washington provided enhanced levels of reimbursement for primary care physician services, to include office and nursing home visits and obstetrical care.

8. Early and Periodic Screening Diagnosis and Treatment

TX	*A	/80	(-)	Texas placed a ceiling or maximum fee on the amount it would pay for EPSDT dental services.

9. Family Planning

KY	*P	/82	(-)	Kentucky proposes to specify a lesser fee schedule for family planning services performed by an advanced registered nurse practitioner than that paid for services performed by a physician.

10. Intermediate Care Facility (ICF)

AL	*P	2/82	( )	The Alabama legislature reported the introduction of a bill to create a Pediatric and Long Term Care Commission which would be responsible for establishing Medicaid nursing home reimbursement rates (S.58).
AR	*A	7/81	(-)	Arkansas changed its methodology of nursing home reimbursement by moving from a facility rate to a strict class rate. It pays at the 80th percentile for each of six classes of nursing homes. An incentive factor was eliminated.
AR	*A	/78	(-)	Arkansas implemented the following changes in the state's nursing home reimbursement methodology: • established rate ceilings; • set reimbursement according to peer groupings; • tied reimbursement rates to grades of patient disability; • indexed reimbursement rate to economic trend factors; and • began imputing a useful lifetime of 40 years to nursing home facilities.
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CO	*A	/81	( )	The Colorado agency has enacted a program which directly funds community mental health centers for psychiatric services provided to nursing home residents.
CO	*A	/81	(-)	Colorado Medicaid implemented a new law (SB38) which included a local Medicaid match requirement for nursing home care, and a decrease in the local Social Services (Title XX) match requirement for non-institutional (e.g., homemaker) services.
CT	*P	7/82	(-)	Connecticut has proposed regulations to alter the reimbursement system for nursing homes by capping rates at 150% of the statewide median rate. Anticipated savings will be utilized to pay extra incentive allowances where nursing homes fall below the median state-wide rate.

FL	*P	7/82	(-)	Florida has proposed that nursing homes participating in Medicaid must be certified for Medicare as well, thus allowing the state to capture the Medicare payments currently being by-passed due to certain facilities being Title XIX-certified only.
FL	*P	2/82	(-)	The Florida legislature reported that a bill had been introduced to create a new reimbursement plan for long term care facilities passed upon: 1) single level of payment; 2) geographic and size classifications; and 3) incentives for efficiency and quality (HB742).
GA	*A	11/81	(-)	Georgia decreased the overall growth allowance for nursing homes from the current rate of 12.6% to 4.5%, and eliminated the usual rate adjustment at the end of the calendar year.
HI	*C	7/82	(-)	Hawaii is considering the development of a prospective reimbursement system for nursing homes. (Projected Savings: $4 million.) An alternative also being considered is the placement of a ten percent cap on cost increases, per facility.
ID	*A	1/82	(-)	The State of Idaho has implemented a new nursing home reimbursement system which has the following characteristics: • it classes facilities by type (i.e., hospital-based, freestanding SNF/ICF, freestanding ICF, or ICF-MR); • it places prospective caps on maximum payments by class of facility; • it pays providers who are below the cap an "efficiency incentive"; and • it recaptures depreciation paid providers if they sell the home for more than the historical cost plus depreciation paid.
IA	*A	4/82	(-)	Iowa reduced ICF reimbursement to the maximum RCF (Residential Care Facility) payment rate for resident recipients when it is determined they do not require the ICF level of care. A residential care facility is a facility providing a lower level of care which is reimbursed with state funds only, since it is not eligible for Title XIX funds.
IA	*A	4/82	(-)	Iowa reduced the rate for reserved bed days for ICF residents from 80% to 75% of allowable costs.
KY	*A	7/81	( )	Kentucky changed the reimbursement methodology for dual-licensed pediatric facilities to a prospective payment rate taking into account current economic conditions and increasing the upper limit of reimbursement to $55.
KY	*A	4/81	( )	Kentucky altered its policy on the gain on sale of nursing home facilities from 8 1/3 years to 12 1/2 years in determining allowable costs of transactions.
ME	*P	7/82	(-)	Maine proposes to implement a prospective reimbursement system for Intermediate Care Facilities.

MI	*A	1/82	(-)	The State of Michigan reduced the maximum profit factor for proprietary ICFs from $1.25 per patient day to $1.00.
MN	*A	3/82	(-)	The Minnesota legislature enacted a bill to require annual audits of some nursing homes, at least 5% of which would be randomly selected and 20% selected by various factors (SF1605).
MO	*P	1/82	(-)	The Missouri legislature reported the introduction of a bill to revise its cost-related reimbursement systems for inpatient hospital and nursing home services (HB1089).
MO	*P	1/82	(-)	The Missouri legislature reported the introduction of a bill to limit nursing home reimbursement to the provider's per diem times a percentage of between 75% and 90% of licensed bed capacity and to limit reimbursement for new facilities to 110% of the original CON estimate (HB1953).
NE	*P	3/82	(-)	Nebraska has proposed to implement a prospective reimbursement system for nursing home facilities.
NV	*C/D	/82	(-)	Nevada is considering a pilot project involving capitation payments to LTC facilities for all physician services provided to LTC patients.
NV	*C/D	/82	(-)	Nevada is considering a demonstration project to provide a capitation payment to LTC facilities for prescription drugs provided to LTC patients.
NV	*A	1/82	(-)	Nevada has advised its LTC facilities that the prospective cost areas (administration and housekeeping) will not be increased in CY 82.
NH	*P	/81	(-)	New Hampshire applied for a waiver to reimburse for services to nursing home patients through direct provider payments for covered medically necessary services rather than applying medical costs in excess of the established limits to the cost of care and thus adjusting the reimbursement to the nursing home. The waiver was denied.
NJ	*P	2/82	( )	The New Jersey legislature reported the introduction of a bill to create a new State authority to assist, in finding sources of capital for nursing homes that allocate at least 75% of their beds to Medicaid patients (A707).
NJ	*C	/82	(-)	New Jersey is considering recognizing only one level of ICF care in order to save on administrative costs.
NJ	*A	11/81	(+)	Increased the long term care pharmacy capitation rate.
NJ	*A	9/81	(-)	Reduced nursing home screens for reimbursement purposes.
NY	*P	1/82	(-)	The New York legislature reported that a bill had been introduced to deny reimbursement to residential health care facilities for costs associated with employee labor organizations (A9388).

OK	*A	1/81	(+)	Oklahoma raised per diem rates for ICF services.
PA	*P	7/82	(-)	Pennsylvania is proposing to cease, as of July, 1982, payment to nursing homes for depreciation and interest costs unless the institutions have received Certificate of Need (CON) prior to July, 1982.
PA	*A	2/80	(+)	Pennsylania raised reimbursement ceilings for ICFs and SNFs.
RI	*A	1/82	(-)	Rhode Island modified its nursing home reimbursement methodology, principally by dropping the Consumer Price Index (CPI) as the economic index used in computing inflation-related increases in reimbursement levels. In its place, it adopted HCFA's National Nursing Home Input Price Index, which is more reflective of nursing home costs. In addition, rate increases tied to economic trends will no longer apply to cost centers for interest and depreciation.
SC	*A	7/82	(-)	South Carolina is in a transitional phase, moving from the use of the Consumer Price Index to a local index (designed by the South Carolina Division of Research and Statistical Services, Budget Control Board) in determination of the inflation factor used in computing nursing home reimbursement rates. The transition will be completed in July 1, 1982.
SC	*A	11/78	(-)	Because of an excess of SNF beds, South Carolina allowed dual licensure of some SNF's so that they could also provide ICF services. Reimbursement for these facilities is made at a composite rate, based upon the total cost of itemized patient days.
SD	*P	1/82	( )	The South Dakota legislature reports that a bill has been introduced to limit private pay nursing home rates to 110% of Medicaid rates for homes participating in Medicaid (SB 218).
VA	*C	/82	(-)	Virginia is considering making substantial changes in its nursing home reimbursement methodology.
VA	*A	7/81	(-)	The State of Virginia increased the minimum occupancy requirement of its prospective reimbursement system from 85% to 95% for certified nursing homes (distinct parts) over 30 beds. Certified units of 30 beds or less, e.g., small SNF distinct parts, will maintain the previous 85% occupancy requirement.
VA	*A	7/81	(-)	The State of Virginia made the following changes in the manner in which it reimburses for capital costs: (1) It reduced its construction cost limit for new facilities and bed additions to a reimbursable maximum of $22,965 per bed if 3 independent bids are obtained and the provider accepts the most prudent bid except where the nursing home operator or related party serves as the contractor. Bids must be obtained in an open competitive manner and full disclosure will be required by the Program prior to initial rate setting. Operator/contractors and related party's reimbursable costs will continue to be limited to the

lower of the effective Construction Cost Limit or allowable cost as defined by Medicare principles of reimbursement.

(2) The reimbursable Construction Cost Limit will be adjusted annually on a calendar year basis using Dodge Construction Systems Costs for a 385 sq. ft. per bed "high average" cost facility. The above limit will be adjusted on January 1, 1982 and will apply to all new nursing home beds licensed on or after October 1, 1982. The limit will be adjusted annually thereafter using Dodge Construction Systems Costs. The current limit will remain in effect until October 1, 1982.

(3) All providers must have an approved Certificate of Need prior to becoming enrolled as Medicaid providers. In the event of a sale of a nursing home, the purchaser must have a valid Certificate of Public Need in order to receive Program reimbursement.

(4) Reimbursement will not be made for costs in excess of those aproved by the State Health Commissioner under the Certificate of Public Need law and regulations.

VA *A 7/81 (-) The State of Virginia also made changes in its reimbursement policies affecting the financing of nursing home costs. The state will continue its policy to disallow cost increases due to the refinancing of existing debt except in cases of expansion or renovation when required by the mortgage holder. Refinancing will be permitted in cases where refinancing would produce a lower rate and result in cost savings.

Financing for all new facilities and expansions initially licensed after September 30, 1982, for all major renovations which require a Certificate of Public Need completed on or after September 30, 1982, and for all purchases occurring on or after June 30, 1981 will be subject to the following limitations:

(a) Interest expenses will be limited to not more than rates authorized by the Virginia Housing Development Authority on the dates of commitment for construction financing and closing of the permanent financing. Where Bond Issues are used as the source of permanent financing, the date of sale will be considered as the date of closing.

(b) The aggregate of the following financing costs will be limited to 5% of the effective construction cost limit:

Examination fees
Guarantee fees
Financing expenses (Service fees, placement fees, feasibility studies, etc.)
Underwriters' discounts
Loan points

(c) The aggregate of the following financing costs will be limited to 2% of the effective construction cost limit:

Legal fees
Organizational costs
Cost certification fees
Title and recording costs
Printing and engraving costs
Rating agency fees

(d) In compliance with Medicare principles of reimbursement the Program will continue to disallow costs associated with mortgage life insurance premiums and debt reserve funds.

VA *A 7/81 (-) The State of Virginia also made the following changes in its policies concerning the purchase of existing facilities:

1. Appraisals must now include a breakdown by cost category for a minimum of the following items:

   a – Building
   b – Fixed Equipment
   c – Moveable Equipment
   d – Land

2. The estimated remaining useful economic life of the three categories of building, fixed equipment, and moveable equipment must be included in the appraisal. This information will be utilized to compute depreciation schedules.

3. The seller of the facility shall make a retrospective settlement with the Program in instances where a gain was made on disposition. The Program will recapture the total amount of depreciation paid to the provider by the Program for the period of participation in the Program in the event the gain equals or exceeds total depreciation expenses. No depreciation adjustment will be made in the event of a loss or abandonment. A final cost report and refund of depreciation expense, where applicable, will be due within 90 days from the date of the consummation of the sale.

VA *A 7/81 (-) The State of Virginia made the following changes in its nursing home reimbursement policies:

1. With respect to the cost of living increase rate, the add-on to the rate of change of the Consumer Price Index (CPI-U) will be reduced from 2% to 1% for those providers under prospective reimbursement. Effective for fiscal periods beginning on or after July 1, 1982, the add-on will be eliminated entirely and the cost of living rate will be based strictly on the percentage change in the average CPI-U.

2. The operating cost limit for providers under prospective reimbursement was reduced from 135% to 125% of the per diem statewide average operating cost.

3. Costs claimed for legal fees are now limited to fees for services rendered and must be related to patient care as defined by Medicare principles of reimbursement. Documentation for legal costs must be available at the time of audit. Retainer fees are considered allowable.

   Leases approved prior to August 18, 1975, are to have the terms of those leases honored for reimbursement throughout the duration of the lease. Renewals and extensions to these leases will be honored for reimbursement purposes only when the dollar amount negotiated at the time of renewal does not exceed the amount in effect at the termination date of the existing lease. No escalation clauses will be approved.

4. Effective for cost reports filed after July 1, 1981, a new facility shall have an interim rate determined using a pro forma cost report or detailed budget prepared by the provider which presents its anticipated allowable cost for the first cost report period of participation. This rate shall be subject to retroactive adjustment to actual allowable Program cost following the review and audit of the initial cost report.

5. A new facility's costs are subject to retroactive adjustment to actual allowable Program costs for the first and second cost reporting periods of operation.

6. A new facility shall have a prospective operating cost rate set for its third cost reporting period. During the third period it will be eligible to participate in the cost efficiency and cost savings incentives.

7. The per diem operating cost rate for a new facility shall not exceed 140% of the applicable statewide per diem average operating cost in each of its first two cost reporting periods. During the first two cost reporting periods, the occupancy limits stated elsewhere will not apply.

WA *C /82 (-) The Washington legislature is considering legislation which would reimburse nursing homes on the basis of cost centers: patient care, food, administration and operation, and property, plus a return on equity. The bill would permit a 20% shift between cost centers excluding property (SB3765).

WA *P 7/82 (-) The State of Washington is pursuing capitation reimbursement alternatives for prescriptions provided to nursing home patients.

WA *A 7/82 (-) The State of Washington will implement various rate cost-savings initiatives in the nursing home program:

a) cut back scheduled increase for patient care enhancement;
b) cut in half reimbursement for specialty consultants;
c) cut back scheduled inflation increase;
d) pay only for nurse aide training actually provided.

WA	*A	11/81	(-)	The Washington State legislature proposed a bill to reduce nursing home reimbursement rates for various cost centers and to increase collection of overpayments to nursing homes (SHB760).
WI	*A	12/81	(-)	Wisconsin established a policy of fining an ICF or SNF between $10 and $100 for each day that it refuses to recover Medicare costs or obtain Medicare certification.
WI	*A	5/81	(-)	Wisconsin limited its reimbursement for reserve bed days to only those LTC facilities with occupancy rates of 93% or more.
WI	*A	5/81	(-)	Wisconsin incorporated funding of incontinency supplies into its LTC facility per diem rate.

11. Intermediate Care Facility Services for the Mentally Retarded

CA	*P	1/82	(-)	California proposes to increase paid leave days for nursing home patients in certain programs for the mentally disordered from 18 to 30 days per year, separately define "bed holds" as days when patients are in acute care facilities, and reduce reimbursement for all leaves and "bed holds" by $2.31 per day.
CT	*P	7/82	(-)	Connecticut has proposed regulations to alter the reimbursement system for nursing homes by capping rates at 150% of the statewide median rate. Anticipated savings will be utilized to pay extra incentive allowances where nursing homes fall below the median state-wide rate.
KY	*A	4/81	(-)	The state's nursing home reimbursement system contains a cost incentive and investment factor which is intended not only to provide a margin of profit for proprietary facilities, but also is structured in such a way as to provide a maximum return for those facilities with the lowest per diem costs and thus, provides an incentive for cost containment. This factor is standardized for the skilled and intermediate levels of care at the $2.25 level. The maximum daily payment for ICF-MRs is $90.00
NV	*A	1/82	(-)	Nevada has advised its LTC facilities that the prospective cost areas (administration and housekeeping) will not be increased in CY 82.
OK	*A	1/81	(+)	Oklahoma raised per diem rates for ICF-MR services.

16. SNF Services for those under 21

KY	*A	7/81	( )	Kentucky change the reimbursement methodology for dual-licensed pediatric facilities to a prospective payment rate taking into account current economic conditions and increasing the upper limit of reimbursement to $55.
MI	*A	1/82	(-)	Michigan reduced the maximum profit factor for proprietary SNFs from $1.25 per patient day to $1.00.

20. Personal Care Services

MN	*A	/81	(+)	Minnesota increased the monthly maximum for personal care services from $800 to $100 and the hourly maximum from $4.50 to $5.00.
OK	*A	1/82	(+)	Oklahoma raised per diem rates for personal care services.
OK	*A	1/81	(+)	Oklahoma raised per diem rates for personal care services.

21. Emergency Hospital Services

CT	*P	11/81	(-)	The Connecticut legislature reported that a bill had been introduced to reimburse hospital outpatient clinics and emergency rooms at a rate not to exceed 150% of the combined average fee of a general practitioner and specialist office visit (H9010X).
DC	*P	5/82	(-)	The District of Columbia is considering a proposal to place a limitation of 109% of audited FY80 costs on reimbursement levels for hospital outpatient and emergency room services.
GA	*A	11/81	(-)	Georgia began reimbursing Emergency Room visits for minor and chronic illnesses at a flat rate of $10 per visit. This is an all-inclusive rate.
VT	*A	7/81	(-)	Vermont ceased paying emergency room rates to emergency rooms for non-emergency services delivered between 8:00 am and 4:00 pm on weekdays. Reimbursement is at physician rate levels.

22. Prescribed Drugs

CA	*P	3/82	(-)	The California legislature reported the introduction of a bill that would reimburse mental health and drug services under the Short-Doyle program to the lower of reasonable costs or customary charges. The bill also requires the Department of Health Services to establish rates and a rate-setting methodology for these Short-Doyle services (AB528).
CA	*P	1/82	(+)	The California state legislature has introduced a bill which requires that allowable drug product prices be updated every 60 days and that regulations affecting prices or exclusion of a drug from the formulary not take effect until 30 days after pharmacies have been notified (AB1334).
FL	*P	1/82	(+)	The Florida legislature reports that a bill has been introduced to increase professional service fees paid to pharmacies and to increase the fees on a regular basis (HB401).
FL	*A	/81	(-)	In Florida the adjustment to the standard drug allowance of $22 and $33 for community and nursing home recipients respectively will be initiated from now on by the pharmacist. The shift of initiation of a Drug Exception Request (often used in cases where drug maintenance is necessary or a long-term illness is involved) from the physician to the pharmacist will provide a much more efficient system for determining drug allowances.
GA	*A	11/81	(-)	Georgia limited reimbursement to physicians for injectable drugs administered in the office to no more than the generic cost of the drug.
GA	*A	11/81	(-)	Georgia has established maximum allowable costs (MAC) for certain highly utilized generic products.
GA	*A	11/81	(-)	Georgia lowered its pharmacy dispensing fee from $3.32 to $2.93. This rollback made the fee 3% higher than the pre-April, 1981 fee of $2.85, bringing pharmacy increases into line with the 3% maximum increase imposed upon reimbursement of physicians, podiatrists, psychologists and independent labs.
GA	*A	4/81	(+)	Georgia increased its pharmacy dispensing fees from $2.85 to $3.32.
HI	*A	6/80	(-)	Hawaii revised its method of reimbursing pharmacists by paying cost plus a dispensing fee.
KY	*A	7/81	(-)	Kentucky began limiting the amounts payable for drugs, including: requiring use of the latest available prescription pricing guide; and limiting the number of dispensing fees allowed in a month.

ME	*A	1/82	(+)	The state of Maine has increased its prescription drug dispensing fee from $2.70 to $3.20. (It should be noted that at the same time, the state has initiated a $.50 copayment on prescription drugs.)
MI	*P	4/82	(-)	The State of Michigan is considering the volume purchase of hearing aids, laboratory services, and drugs.
MN	*A	/82	(-)	Minnesota will reimburse for drugs at the actual acquisition cost of the drug plus a fixed dispensing fee.
MO	*P	5/82	(-)	Missouri has proposed to require after-the-fact billing of nursing home drugs.
NE	*P	1/82	(-)	Nebraska has proposed to establish a state maximum allowable charge for certain drugs. (Estimated Savings: $100,000.)
NV	*C/D	/82	(-)	Nevada is considering a demonstration project to provide a capitation payment to LTC facilities for prescription drugs provided to LTC patients.
NJ	*A	11/81	(+)	Increased the long term care pharmacy capitation rate.
NJ	*A	10/81	(+)	New Jersey increased the pharmacy dispensing fee.
NM	*P	2/82	(-)	The New Mexico legislature reported that a bill had been introduced to allow pharmacists to prescribe equivalent drugs and to limit reimbursement to the wholesale cost of the less expensive equivalent drugs plus a dispensing fee. (HB114)
ND	*C	6/82	(-)	North Dakota is considering a competitive bidding process for purchase of eyeglasses and hearing aids.
OH	*P	2/82	(-)	The Ohio legislature reports introduction of a bill to appoint a medical assistance pharmacy ombudsman to assist providers in claims processing (SB472).
OK	*A	11/81	(+)	Oklahoma increased its prescription drug dispensing fee from $3.27 to $3.55. (Estimated additional cost: $1.5 million.)
PA	*A	5/81	(+)	Pennsylvania increased its drug dispensing fee by $.25.
RI	*P	4/82	(-)	Rhode Island proposes to modify its policies regarding maintenance drugs, requiring that they be prescribed in quantities of 100 tablets or capsules or a pint of liquid, or a one-month's supply, whichever is greater. Exceptions will be made for certain medical reasons, in extraordinary cases, and for the initial prescription of a drug. This policy should reduce outlays for dispensing fees of these drugs.

VT	*A	2/82	(+)	Vermont increased its pharmacy dispensing fee from $2.15 to $2.50.
VA	*A	7/82	(-)	Virginia established a drug payment maximum at the 75th percentile of the range listed in the Virginia formulary.
WA	*P	7/82	(-)	The State of Washington is pursuing capitation reimbursement alternatives for prescriptions provided to nursing home patients.
WA	*A	2/82	(-)	The State of Washington implemented an Estimated Acquisition Cost reimbursement system for prescription drugs.

23. Dental Services

KY	*A	9/81	( )	Kentucky changed the method for determining dental service charges by basing the charge on the overall patterns in the state, rather than pattern established in 16 separate medical service areas. It established that the Title XVIII, Part B aggregate prevailing charge data will be used in determining payments rather than the "reasonable charge profiles and current "prevailing charge data".
ME	*A	1/82	(+)	The state of Maine has increased its fees for dental services (with the exception of orthodontia) by approximately 9 percent, overall. This reflects an increase in the maximum allowances for most general dental procedures.
SC	*A	2/82	(-)	South Carolina adopted fee schedules for dental care, vision care and durable medical equipment. The previous method of reimbursement was fee for service at usual and customary rates.
TX	*A	/80	(-)	Texas placed a ceiling or maximum fee on the amount it would pay for EPSDT dental services.

25. Clinic Services

CA	*P	3/82	(-)	The California legislature reported the introduction of a bill that would reimburse mental health and drug services under the Short-Doyle program to the lower of reasonable costs or customary charges. The bill also requires the Department of Health Services to establish rates and a rate-setting methodology for these Short-Doyle services (AB528).
CO	*A	/81	( )	The Colorado agency has enacted a program which directly funds community mental health centers for psychiatric services provided to nursing home residents.
GA	*A	11/81	(-)	Georgia began limiting reimbursement to the Community Mental Health Centers to a maximum of the 50th percentile of current rates.
GA	*A	11/81	(-)	Georgia eliminated reimbursement to mental health clinics for "medication monitoring." It had previously reimbursed clinics separately for medication administration and medication monitoring, but now reimburses only for the former.
IL	*A	1/82	(+)	The State of Illinois, as part of its revised hospital reimbursement approach (see III1) rescinded the changes in its OPD and clinic reimbursement methodologies which were adopted in July, 1981 (see earlier entry).
IL	*A	1/82	(-)	The State of Illinois revised its reimbursement methodology for hospital inpatient, outpatient, and clinic services. See Section III1 for details.
KY	*P	/82	( )	Kentucky proposes to lower the upper limit on allowable costs by setting it at the median visit cost by service area rather than 100% of the median visit cost. It would modify reimbursement by basing on actual allowable cost rather than prior year actual allowable cost.
KY	*A	10/81	(-)	Kentucky lowered its maximum payment level from 110% to 100% of the median cost of the participating Community Mental Health Centers for each of the four service categories.
KY	*A	6/81	( )	Kentucky began prohibiting reimbursement for political contributions, membership dues, travel and related costs for trips outside the state and legal fees for unsuccessful lawsuits to mental health centers.

26. Eyeglasses

CT	*P	11/81	(-)	The Connecticut legislature reported that a bill had been introduced to establish competitive bidding for eyeglasses and other corrective vision aids (H9010X).
KS	*A	3/82	(+)	Kansas increased its reimbursement levels for certain opthalmic materials.
MI	*A	11/81	(-)	Through a competitive bid process, the State of Michigan has entered into a volume purchase arrangement with Hess Optical Labs for eyeglass lenses and frames. The previous contractor was Bausch & Lomb.
WA	*A	10/75	(-)	The State of Washington contracted with one statewide contractor for the fabrication and assembly of eyeglasses.

27. Optometrists' Services

KY	*A	9/81	( )	Kentucky established new reimbursement mechanisms for optometrists and ophthalmic dispensers based on the usual, customary and allowable charges.
SC	*A	2/82	(-)	South Carolina adopted fee schedules for dental care, vision care and durable medical equipment. The previous method of reimbursement was fee for service at usual and customary rates.

31. Rehabilitative Services

MI	*C	/82	(-)	The Michigan Medicaid program is holding discussions with Michigan Rehabilitation Services on the subject of more effective use of monies for clients enrolled in both agencies' programs. This would include elimination of possible double billing for services.
NJ	*A	9/81	(-)	The State of New Jersey reduced the reimbursement rate for medical day care services by 10%.

32. Podiatrists' Services

GA	*A	11/81	(-)	Georgia limited the maximum allowable payments for podiatric services to no more than 3% above current rates.

34. Other Practitioners

GA	*A	11/81	(-)	Georgia limited the proposed increase in the maximum allowable payments to psychologists to no more than 3% above current rates.
HI	*P	2/82	(-)	The Hawaii legislature reports introduction of a bill to allow reimbursement for nurse-midwives (SB2385-82).
MA	*P	2/82	(-)	The Massachusetts legislature reported the introduction of a bill to authorize reimbursement for nurse midwife services (H3961).
PA	*P	/82	(-)	Pennsylvania proposes to directly reimburse midwives for their services, making them the only para-professionals to be paid directly by the state.

36. Physical Therapy

MI	*P	1/82	(-)	Steps are underway within Michigan to implement direct enrollment of physical therapists as providers. Coverages are not affected, but better control over billing and Medicare payments will be achieved.
MI	*C	/82	(-)	The State of Michigan is giving consideration to direct enrollment, and reimbursement, of physical therapists. (They are now enrolled through physicians, home health agencies or nursing homes.) Fee screens could then be applied and would provide more effective limits on reimbursement.

39. Prosthetic Devices

MI	*P	4/82	(-)	The State of Michigan is considering the volume purchase of hearing aids, laboratory services, and drugs.
MO	*P	3/82	(-)	Missouri has proposed to allow only one hearing aid dispensing fee per person (not a dispensing fee for each hearing aid for both ears if two hearing aids are medically needed).
NJ	*P	4/82	(-)	The State of New Jersey is proposing to change, effective April 1, 1982, the method of reimbursement for hearing aids from manufacturers list price less 20% to a single unit cost plus a dispensing fee.
ND	*C	6/82	(-)	North Dakota is considering a competitive bidding process for purchase of eyeglasses and hearing aids.

42. Durable Medical Equipment and Supplies

GA	*A	11/81	(+)	Georgia limited all reimbursement for durable medical equipment to existing Medicare rates and limited coverage to 75 items.
GA	*A	11/81	(-)	Georgia limited reimbursement for DME (durable medical equipment) delivery mileage to one-way.
ME	*P	5/82	(+)	The state of Maine has proposed to change its method of reimbursing for durable medical equipment and medical supplies. Payment was previously based on a pre-determined maximum allowance which did not reflect changes in the cost of the goods. The new method of calculating the maximum allowance takes into account the cost of the good to the provider and adds a 30 to 50 percent markup, depending upon the cost of the item.
SC	*A	2/82	(-)	South Carolina adopted fee schedules for dental care, vision care and durable medical equipment. The previous method of reimbursement was fee for service at usual and customary rates.
WA	*A	8/79	(-)	The State of Washington entered an ordering agreement with one statewide contractor for the provision of oxygen and respiratory therapy.

43. Transportation

CT	*P	2/82	( )	The Connecticut legislature reports introduction of a bill to reimburse ambulance service at the Medicare rate (H5428).
CT	*P	11/81	(-)	The Connecticut legislature reported that a bill had been introduced to limit reimbursement to $60 per trip for ambulance services and $6.50 per trip for other transportation (H9010X).
FL	*A	7/81	(-)	Florida increased the reimbursement rate for individuals providing transportation to Medicaid recipients in their privately-owned vehicles from 7½ cents per mile to 19¢ per mile. It was hoped that this move would encourage this mode of transportation as opposed to the use of more expensive taxicabs, which were currently being used predominantly. Early data suggests a trend toward greater use of privately-owned vehicles.
FL	*A	7/81	(-)	Florida allocated 10% of the transportation budget to the districts at the administration match to allow for local purchase of service contracts with low-cost transportation providers.
GA	*A	11/81	(-)	Georgia began reimbursing non-emergency ambulance transportation at a base rate of $30 plus 70¢ per mile. It eliminated in- and out-of-county reimbursement differences in reimbursement amounts.
GA	*A	11/81	(-)	Georgia began reimbursing volunteer private automobile transportation according to scale rates for multiple passengers: 20¢ per mile for first passenger; 10¢ per mile for second passenger; and 5¢ per mile for each additional passenger.
OR	*A	10/81	(-)	Oregon established maximum fees for transportation services. Medicare rates were used for those services which Medicare also covers.
VA	*A	7/81	(-)	Virginia reduced non-emergency transportation costs by using uniform reimbursement rates.

Administration and Management

IV. ADMINISTRATION AND MANAGEMENT

A. Reducing Eligibility Errors

CA	*D	1/82	(-)	California will implement a demonstration project Earnings Clearance System in which Medicaid Eligibility Records will be matched with other state files containing earnings information.
CA	*A	7/81	(-)	California's Medi-Cal Eligibility System Redesign Project makes use of on-line data processing systems which link local welfare departments to a statewide file of Medi-Cal eligibles. It is expected to decrease the number of temporary Medi-Cal cards issued, and erroneous payments made. By the end of FY 81-82, it will be 60% implemented, with 100% implementation by the end of 1983.
MD	*P	10/82	(-)	Maryland is developing an eligibility verification system. ID cards for Medicaid eligibles list an expiration date, usually three months from the date of issue. Heretofore, Maryland has reimbursed for services provided between the time of a cancellation in coverage and the expiration date on the ID card. However, with the implementation of a new automated on-line system for providers' use in verifying eligibility, providers will be placed at risk and will not be reimbursed for services provided to ineligible patients. The system can be accessed 24 hours a day by the use of a touch-tone telephone.
MA	*A	2/82	(-)	Massachusetts centralized eligibility determination and redetermination for long term care cases.
MA	*C	2/82	(-)	Massachusetts is considering revising criteria used to prioritize cases for redetermination.
MA	*D	2/82	(-)	Massachusetts improved identification of recipient assets through the use of tape matches with bank service bureaus.
MA	*P	1/82	( )	The Massachusetts legislature reported that a bill had been introduced requiring that the Medicaid eligibility of residents in state schools for the mentally retarded be redetermined at least once every twelve months (H192).
MA	*P	1/82	(-)	The Massachusetts legislature reported that a bill has been introduced to implement a complete identification system of recipients (S676).
MA	*P	/82	(-)	Massachusetts is considering a procedural change to automate redeterminations for medically needy.
MA	*A	12/81	(-)	Massachusetts instituted error-prone profiling for the medically needy.
MA	*D	12/81	(-)	Massachusetts developed a supervisory review instrument for Medicaid to ensure accuracy of redeterminations.

MA	*A	12/81	(-)	A new Medical Assistance Policy Manual and Medical Assistance Procedures Handbook have been issued in order to ensure consistency of eligibility determinations throughout the State.
MI	*A	9/80	(-)	Michigan implemented a consolidated application form for assistance programs.
MI	*A	/80	(-)	Michigan developed handbooks designed to provide step-by-step instructions for determining eligibility for medical assistance. The eventual goal is to establish an on-line eligibility system.
NJ	*A	/81	(-)	The State of New Jersey has instituted a Medicaid/CODES Interface system in 11 of their 21 counties, and will expand it to the entire state in 1982. This a link-up between their Medicaid and welfare files to reduce eligibility errors.

B. Maximizing Payments from Other Sources

AL	*A	6/81	(-)	Alabama implemented a pilot project to cooperate with the Welfare Office in efforts to recover support from absent parents of recipients.
CA	*A	7/82	(-)	California statutes now provide that counties may contract with the Department of Health Services for the detection and collection of debts due from Medi-Cal beneficiaries who have been retroactively determined to be wholly or partially ineligible for services received. An incentive of 10% of net General Fund collections after costs is provided to the counties.
CA	*A	7/82	(-)	California statutes now require the Department of Health Services to maximize identification of private health care coverage through provision of technical assistance to counties. Counties will be reimbursed for costs associated with gathering the data. The Department of Health Services will computerize the data, gather patient histories and bill insurance companies for services.
CA	*A	3/82	(-)	Recent changes in California law now require the Department of Health Services to contract with third party liability contractors to recoup payment for health services for Medi-Cal beneficiaries. It is expected that a substantial amount of funds will be collected from third party payors through these contracts.
CA	*A	1/82	(-)	The California Workers' Compensation Appeals Board is now required to exchange information with the Department of Health Services to assure that Medi-Cal services that are reimbursable through Workers' Compensation are identified.
CA	*A	1/82	(-)	California state law now provides for recovery of health care costs from the estates of over-age-65 Medi-Cal beneficiaries in certain instances.
CA	*A	10/81	(-)	A new computer process in California will begin to claim, on an ongoing basis, Federal Financial Participation for costs of those state-only Medi-Cal cases who are retroactively eligible as federally-linked disabled individuals.
CA	*A	7/80	(-)	In California a new system has been implemented for claiming Federal Financial participation for pregnancy-related services provided to Medically Indigent Adults whose Medi-Cal services were totally state-funded.
FL	*P	7/82	(-)	Florida has proposed that nursing homes participating in Medicaid must be certified for Medicare as well, thus allowing the state to capture the Medicare payments currently being by-passed due to certain facilities being Title XIX-certified only.
FL	*P	2/82	(-)	The Florida legislature reported the introduction of a bill to expand third party liability efforts (SB583).

FL	*A	/81	(-)	Florida began mailing out Third Party questionnaires to SSI recipients to replace the inadequate Third Party Liability information received on the SDX.
GA	*P	2/82	(-)	The Georgia legislature reported that a bill had been introduced to require children to contribute to the cost of their parents in nursing homes. This bill applies to children having an income of at least $40,000 per year. The maximum amount of the contribution is $4.00 per day (HB1204). This bill is not considered likely to pass.
HI	*P	1/82	(-)	The Hawaii legislature has reported that a bill has been introduced to create a Third Party Liability Recovery Unit within the State Medicaid Agency (HB 2082-82).
HI	*P	1/82	(-)	The Hawaii legislature has reported that a bill has been introduced to create a Third Party Liability Recovery Unit within the State Medicaid Agency (HB 2082-82).
ID	*P	2/82	(-)	The Idaho legislature reported the introduction of a bill to expand third party liability efforts (HB586).
IN	*P	1/82	(-)	The Indiana legislature reported that two bills were introduced to expand TPL efforts: one in the House of Representatives (HB1304); and one in the Senate (SB300), which would require insurers to provide information on Medicaid recipients and to reimburse the state for payment made on claims.
IN	*P	1/82	(-)	The Indiana legislature reported that a bill was introduced to expand TPL efforts by requiring insurers to provide information on Medicaid recipients and to reimburse the state for payments made on claims (SB300).
IN	*P	1/82	(-)	The Indiana legislature reported that a bill had been introduced which would require contribution toward the cost of institutional Medicaid services by children or parents of institutionalized recipients. (This would apply only to those relatives between the ages of 21 and 65.) The Department of Public Welfare will develop a payment scale based on income. The maximum contribution is to be $100/month. Failure to contribute will constitute a Class D felony (SB400).
KS	*P	7/82	(-)	Kansas will implement a third party liability system as part of its MMIS. Claims will be denied on a prepayment basis and the provider will be given information available in the system to assist in billing the third party.
KY	*P	1/82	(-)	The Kentucky legislature reported that a bill had been introduced to create a fund to receive contributions to Medicaid. The bill also gives state income tax deductions to fund contributors and to those caring for the elderly in the home (S36).
MD	*P	2/82	(-)	The Maryland legislature reports introduction of a bill to require that nursing homes have an equal number of Medicaid and private pay patients (HB1026).

MD	*P	1/82	(-)	The Maryland legislature reported the introduction of a bill to expand third party liability efforts. The bill would require insurance carriers to reimburse the state for claims filed within two years of treatment which are based on information sufficient to determine insurer's liability (SB117).
MA	*P	1/82	(-)	The Massachusetts legislature has reported that a bill has been introduced to increase third party liability collection efforts (H177).
MA	*P	1/82	(-)	The Massachusetts legislature reported that a bill had been introduced to expand third party liability efforts by requiring that recipients and insurors provide information on the health insurance coverage of Medicaid recipients (H179).
MA	*P	1/82	( )	Massachusetts has proposed to conduct a mass mailing to absent parents.
MA	*P	1/82	(-)	The Massachusetts legislature reports the introduction of a bill to increase third party liability efforts by requiring insurance companies to provide information on Medicaid recipients.
MA	*P	/82	(-)	Massachusetts is considering a policy change to allow the state to place a lien on provider property, increasing collections from bankrupt providers.
MA	*A	10/81	(-)	Massachusetts instituted the Third Party Resource Training Program for case-carrying field workers to train them to the concepts of people who are likely to have insurance, how to identify the insurance, and what to do with the information once it's identified.
MA	*A	10/81	(-)	Massachusetts developed a hard copy third party resource desk guide which case workers use to identify third party resources during eligibility determinations in case maintenance.
MI	*A	/81	(-)	Michigan's Third Party Liability (TPL) program has had unprecedented success. This success is due to increased experience and efficiency of TPL staff, training of county caseworkers in capturing Third Party resource information, increased effectiveness of prepayment edits, eligibility tape exchanges with large carriers, child support/medical support automated exchange. Program savings for fiscal year 1980/81 were 53 million dollars: $12 Million - Cash $21 Million - Cost Savings + $20 Million - Cost Avoidance $53 Million - Savings
MI	*A	/80	(-)	Michigan has implemented an automated system to identify some absent parents with insurance that would cover their children. Additionally, they have in place manual review procedures to capture insurance information on an experimental basis.

MN	*A	3/82	(-)	The Minnesota legislature enacted a bill to require responsible relatives to pay for the cost of recipient care (HF2123).
MS	*P	1/82	(-)	The Mississippi legislature reported the introduction of a bill to require Medicaid nursing homes to participate in the Medicare program (SB589).
MO	*P	1/82	(-)	The Missouri legislature reported the introduction of a bill to expand third party liability efforts (HB1953).
NV	*A	1/82	(-)	Nevada has refined and expanded its criteria for handling TPL cost avoidance and cost recovery.
NJ	*A	3/81	(-)	The State of New Jersey began matching the Medicaid eligibility file with the Blue Cross eligibility file.
NJ	*P	/81	(-)	The State of New Jersey proposed to develop matches with other health insurers.
NJ	*A	/80	(-)	The State of New Jersey adopted TPL liens and correct payments against estates.
NM	*P	1/82	(-)	The New Mexico legislature reports that a bill has been introduced to allow relatives or religious organizations to contribute up to $300 per month to a nursing home resident, without affecting Medicaid eligibility, and limits the amount earmarked to defray nursing home costs to 50% of the contribution (HB126).
ND	*A	7/81	(-)	North Dakota increased third party liability collection efforts by hiring additional staff.
OR	*P	/82	(-)	The Oregon legislature passed a law which expands the definition of medical assistance to include payments for insurance and other contractual arrangements and money paid to the recipient for the purchase of medical care (SB 889). However, the Medicaid agency has not as of yet implemented it.
PA	*A	/82	(-)	Pennsylvania is developing and improving its third party liability program through its new MMIS system.
SD	*P	/82	(-)	South Dakota is considering strengthening its third party liability recovery efforts.
TN	*P	2/82	(-)	The Tennessee legislature has reported the introduction of a bill to increase TPL efforts through subrogation of rights and imposition of a 10% collection fee (SB2235).
VA	*P	1/82	(-)	The Virginia legislature reports the introduction of a bill to study ways to expand third party liability recovery from absent parents (HJR92).

VA	*A	7/81	(-)	The State of Virginia has revised the income scales it uses to compute the ability of a spouse at home to contribute to the support of his or her husband or wife in a nursing home. The state has a law which requires that an individual support his or her needy spouse and that a parent be responsible for support of his or her children to age 18. The revised scale is based on national poverty levels which are higher than previously used Medicaid income scales.
WI	*A	12/81	(-)	Wisconsin established a policy of fining an ICF or SNF between $10 and $100 for each day that it refuses to recover Medicare costs or obtain Medicare certification.

C. Fraud and Abuse

AL	*A	/81	(-)	The Alabama Welfare and Medicaid agencies began sharing information regarding fraud and abuse of the programs.
CA	*P	1/83	(-)	California proposes to collect overpayments found at audit even if they are appealed. If the provider's appeal is successful, amounts due to the provider are returned with interest.
CT	*P	2/82	(-)	The Connecticut legislature reports the introduction of a bill to reduce fraud by auditing property tax records (H5222).
CT	*P	/82	(-)	The Connecticut legislature is considering a bill which would bar vendors or providers convicted of fraud from participation in the Medicaid program for three years (S178).
FL	*P	2/82	( )	The Florida legislature reported the introduction of a bill to make information pursuant to fraud and abuse investigations confidential (SB636).
IN	*P	1/82	(-)	The Indiana legislature reported that a bill was introduced to: • establish a Medicaid fraud control unit; • prohibit providers from requiring payment from a Medicaid recipient, except when a copayment is required by state law; and • impose sanctions on providers for violations, including: denial of payment for a specified time, denial of provider participation in Medicaid, assessment of fines (not to exceed 3 times the amount of overpayment made to provider), assessment of an interest charge on overpayments (SB299).
IN	*P	1/82	(-)	The Indiana legislature reports the introduction of a bill to set up a fraud control unit and establish sanctions for provider fraud and abuse (HB1304).
KS	*A	1/82	(-)	Kansas began requiring that group providers identify the physician performing the service on their claims forms.
KY	P	2/82	(-)	The Kentucky legislature reports introduction of a bill to impose sanctions for fraud and abuse by recipients or providers (H536).
MD	*P	2/82	(-)	The Maryland legislature reports introduction of a bill to require that nursing homes have an equal number of Medicaid and private pay patients (HB1026).
MA	*P	2/82	(-)	The Massachusetts legislature reported the introduction of a bill to increase the penalties for fraud by recipients and providers (H1164).
MA	*P	2/82	(-)	The Massachusetts legislature has reported the introduction of a bill that would make provider fraud a felony offense (H4795).
MI	*A	4/82	(-)	Michigan began closely reviewing laboratory services for above average use. A provider suspected of abuse will be referred for possible audit and recovery of funds.

MI	*P	1/82	(-)	The Michigan legislature reports that a bill has been introduced authorizing appointment and powers of special investigators to investigate fraud and abuse (S611).
MI	*P	1/82	(-)	The Michigan Legislature reported the introduction of a bill to increase fraud and abuse efforts (S634).
MN	*A	3/82	( )	The Minnesota legislature enacted a bill to require yearly audits of at least 25% of participating nursing homes (SF1605).
MO	*P	2/82	(-)	Missouri has proposed to screen data closely for physicians and podiatrists upgrading the level of office visit billed versus the level of visit actually performed.
MO	*P	2/82	(-)	Missouri has proposed to develop computer edits to verify the medical necessity of physician and podiatrist procedures according to the diagnosis stated on the claims.
NJ	*A	/81	(-)	New Jersey adopted the Tooth Allocation Map Inquiry System (TAMIS), a procedural computer program which places a code on each tooth and is used to flag fraud and abuse of dental services by both providers and recipients (e.g., I.D. card-lending).
NJ	*A	/80	(-)	The State of New Jersey adopted TPL liens and correct payments against estates.
RI	*A	/81	(-)	Rhode Island has incorporated into its administrative procedures for dealing with provider fraud and/or abuse situations, provisions for requiring repayments, payment of penalties and/or delivery of free service.
SD	*C	/82	(-)	South Dakota is considering strengthening procedures to curtail fraud and abuse.
VA	*P	2/82	(-)	The Virginia legislature reports the introduction of a bill to establish a unit under the Attorney General to audit and investigate providers (HB815).
VA	*A	7/81	(-)	The State of Virginia established a policy which would deny Medicaid eligibility to any recipient convicted of fraudulently obtaining or assisting others in fraudulently obtaining Medicaid benefits for a period of 12 months following that conviction.
WA	*C	/82	(-)	The State of Washington has proposed to establish a peer review process with the Washington State Pharmaceutical Association in order to detect fraud.
WV	*P	/82	(-)	The West Virginia Senate passed a bill which defines as a felony any false statement, misrepresentation, or concealment of facts in order to obtain Medicaid eligibility. It is considered likely to pass the State House of Representatives as well (SB 627).

D. Claims Processing

DC	*A	11/81	(-)	The District of Columbia placed a 90-day time limitation on submission of claims by providers, with certain exceptions, for all claims for services rendered on November 6, 1981 or thereafter.
GA	*A	11/81	(-)	Georgia implemented a 100% review of inpatient hospital claims prior to payment, effective January 1, 1982.
IA	*A	4/82	(-)	Iowa required providers to submit claims within 120 days of date of service (previously 365 days).
MA	*P	1/82	(-)	The Massachusetts legislature reported that a bill has been introduced to require providers to report service procedure codes on claims forms (S636).
MI	*P	/83	(-)	The State of Michigan has proposed to begin implementation of a common billing form for hospital providers pending UB-16 finalization. May be done as a HCFA demonstration state.
MI	*C	/82	(-)	The Michigan Medicaid program is holding discussions with Michigan Rehabilitation Services on the subject of more effective use of monies for clients enrolled in both agencies' programs. This would include elimination of possible double billing for services.
MI	*A	/82	(-)	The State of Michigan began meetings to implement a "cross-over" claim system to handle Medicaid/Medicare/Blue Cross-Blue Shield of Michigan liability.
OH	*P	2/82	(-)	The Ohio legislature reports introduction of a bill to appoint a medical assistance pharmacy ombudsman to assist providers in claims processing (SB472).
WA	*A	1/82	(-)	The State of Washington has let a contract for an enhanced MMIS, which will include improved capabilities for claims processing, surveillance and utilization review and program management. This contract is scheduled to be implemented beginning October 1, 1982.
WA	*A	/78	(-)	In 1978 the Regional Medicare contractors and the Washington State Medicaid program began cooperating on claims processing of cross-over claims. Previously, Medicaid had required a denial plan from Medicare before it would initiate processing of a claim. Under the new system, Medicare compiled and updates a list of its covered services, which is incorporated into Medicaid's claims system. Additionally, Medicaid changed from a prior edit of age alone to the Himex/Bendex list provided by the Social Security Administration. Processing costs have been cut in half.

E. Purchase of Service

AL IHPP	*C IVE	/82 Y	( ) *2	In Alabama bills are being considered which would: (1) mandate that contracts for the purchase of services that are required to be competitively bid shall be awarded to the bidder whose proposal is most advantageous to the state (SB11XX); and (2) define competitive bidding procedures (H373).
CA IHPP	*P IVE	3/82 Y	(+) *2	The California legislature reports introduction of a bill to pay in advance counties that provide services based on county costs for the previous quarter (AB2925).
CT IHPP	*P IVE	11/81 Y	(-) *2	The Connecticut legislature reported that a bill had been introduced to establish competitive bidding for eyeglasses and other corrective vision aids (H9010X).
FL	*A	7/81	(-)	Florida allocated 10% of the transportation budget to the districts at the administration match to allow for local purchase of service contracts with low-cost transportation providers.
IA	*C	/82	(-)	The State of Iowa is considering entering into a bulk purchase arrangement for optometric supplies, hearing aids, and durable medical equipment.
KS	*C	/82	(-)	Kansas is considering the bulk purchase of durable medical equipment, medical supplies, and dentures.
MI	*P	4/82	(-)	The State of Michigan is considering the volume purchase of hearing aids, laboratory services, and drugs.
MI	*A	11/81	(-)	Through a competitive bid process, the State of Michigan has entered into a volume purchasing arrangement with Hess Optical Labs for eyeglass lenses and frames. The previous contractor was Bausch & Lomb.
MN IHPP	*A IVE	3/82 Y	(-) *2	The Minnesota legislature reports that a bill has been enacted to require the state to enter into a volume purchasing arrangement for eyeglasses, hearing aids, and durable medical equipment (HF2123).
MO	*P	4/82	(-)	Missouri has proposed to pursue rebate arrangements based on claims volume by drug or manufacturer. The State is currently in contact with four drug manufacturers, but no agreements have yet been reached.
NJ	*C	/82	(-)	New Jersey is considering competitive bidding for selecting providers of independent laboratory services.
ND	*C	6/82	(-)	North Dakota is considering a competitive bidding process for purchase of eyeglasses and hearing aids.

WA	*C	7/82	( )	The State of Washington is considering volume purchasing arrangements for laboratory tests, or, as an alternative, the establishment of payment for common lab procedures at the automated rate.
WA	*A	8/79	(-)	The State of Washington entered an ordering agreement with one statewide contractor for the provision of oxygen and respiratory therapy.
WA	*A	10/75	(-)	The State of Washington contracted with one statewide contractor for the fabrication and assembly of eyeglasses.

F. Other

AL	*A	1/82	(-)	Alabama updated information in its state plan to reflect current policies.
AL	*A	4/81	(-)	Alabama amended the cooperative arrangements with the State vocational rehabilitation, crippled children agencies, Title V grantees and the Title XIX Statewide Family Planning Project by means of which the services administered or supervised by those agencies will be utilized and coordinated with the medical care and services provided by the Alabama Medicaid Agency under the plan.
CA	*P	3/82	(-)	The California legislature reported the introduction of a bill that would require legislative review of any benefit changes having a fiscal impact of greater than $500,000 (AB1700).
CA	*P	1/82	( )	The California legislature reported that a bill had been introduced to prevent providers who act in good faith in making eligibility determinations from having payments withheld (AB2310).
CT	*A	10/81	(+)	Connecticut began requiring that the Commission on Hospitals and Health Care give prior approval to a nursing home's CON before it can terminate a Medicaid provider agreement.
HI	*A	1/82	(-)	Hawaii completed a total revision of its Medicaid rules with the assistance of HCFA, making the language clearer and easier to understand.
KY	P	2/82	(-)	The Kentucky legislature reports introduction of a bill to create mechanisms to collect overpayments (S163).
MD	*P	3/82	(+)	The Maryland Senate reported the introduction of a resolution to require nursing homes to inform residents of the availability of the monthly personal allowance (SJR61).
MA	*P	1/82	(-)	The Massachusetts legislature reported that bills have been introduced to facilitate recovery of overpayments to providers (S482) and H181).
MA	*P	1/82	( )	The Massachusetts legislature reported that a bill has been introduced to require that Medicaid funds for transportation and health aide services be transferred to the Department of Elder Affairs (S595).
MA	*P	1/82	(-)	The Massachusetts legislature reported that a bill had been introduced requiring the Department to distribute to all providers a copy of all Medicaid regulations and establish administrative sanctions for violations (H180).
MA	*P	1/82	( )	The Massachusetts legislature reported that a bill has been introduced to require providers to submit bills no later than 6 months after service has been delivered (S466).

MS	*P	1/82	(-)	The Mississippi legislature reported the introduction of a bill to require that the Department of Public Welfare, Board of Health, and Medicaid Commission coordinate and monitor application procedures for public assistance programs (HB506).
MO	*P	2/82	( )	Missouri has proposed to revise certification criteria (1M.64 form) for skilled nursing and intermediate care. The Division of Aging has the lead on this project.
MO	*P	2/82	(-)	Missouri has proposed to develop a computer edit to identify those nursing homes reporting no patient surplus.
NJ	*P	2/82	(+)	The New Jersey legislature reports the introduction of bills to establish a commission to study the state's Medicaid administrative structure (SCR68 and SCR4).
SC	*P	/82	( )	South Carolina proposes to shift responsibility for the Medicaid program from its Department of Social Services to a new agency, the Health and Human Services Finance Commission.
UT	*A	1/82	(+)	The Utah legislature passed a Joint Resolution to study Medicaid optional services (HJR37).
UT	*A	/81	(-)	Utah entered into 20 interstate agreements with other states for out-of-state recipients of Utah services.
WA	*A	11/81	(-)	The Washington State legislature passed a law to modify regulation of nursing homes by changing the license period from 12 to 36 months, requiring only one inspection for license renewal, and changing night and weekend surveys to a periodic basis (SHB760).
WA	*A	10/81	(-)	The State of Washington implemented a care provider agreement for all Medicaid providers with the exception of nursing homes. This revised agreement provides a clear statement of rules and regulations which apply to participation in the Medicaid program.
WI IHPP	*P IVF	2/82 Y	(-) *2	Wisconsin has requested a federal waiver to modify its LTC utilization control and survey and certification processes. The modifications sought have already been validated through a four-year 1115 demonstration. The plan would reduce the paperwork burden on nursing home operators and state and federal staff, allow more flexibility in the timing of inspections and afford a more realistic policy for plans of correction. (Anticipated annual savings: $6 million.)
WI IHPP	*P IVF	1/82 Y	(-) *2	The Wisconsin legislature has reported that a bill has been introduced to allow counties that assist in recovering incorrect or fraudulent Medicaid payments to retain 25% of the amount recovered (AB992).
WI NGA	*A IVF	12/81 Y	(-) *2	The Wisconsin legislature has passed a law which authorizes the state Medicaid agency to restrict recipients to alternative economical provider arrangements which allow reasonable access to health care of adequate quality.

Eligibility

V. ELIGIBILITY

A. Coverage of Optional Groups

AL	*A	11/81	(-)	Discontinued Medicaid coverage for children between 18 and 21 years of age certified for Medicaid only.
AL	*A	11/81	(-)	Discontinued certification of unborn children for Medicaid coverage. Pregnant women will continue to be certified for Medicaid as long as eligible.
CA	*A	1/82	(-)	A recently passed California law brings the state into compliance with federal AFDC regulations and restricts eligibility of aliens (AB2-X).
CO	*P	2/82	(+)	The Colorado legislature reports introduction of a bill to create a medically needy program limited to the following services: inpatient and outpatient hospital, home health, clinic, lab and x-ray, prescribed drugs, physicians, and rural health clinics (SB125).
CO	*A	/81	(+)	Colorado implemented a new law (SB38) which provided for a pilot program of state-only funding for home health care for non-categorically eligible patients.
GA	*A	11/81	(-)	Georgia eliminated from Medicaid eligibility: (1) persons aged 18-20 years who would be eligible for Aid to Families with Dependent Children (AFDC) if they met the AFDC age or school attendance requirements, and (2) persons aged 18-20 years who are in foster homes or private institutions for whom a public agency is assuming a full or partial financial responsibility.
HI	*A	/81	(+)	Hawaii added coverage of financially eligible children who aren't otherwise eligible for Medical Assistance and for whom public agencies are assuming full or partial financial responsibility in private child-caring facilities, foster homes, ICF's or SNF's.
HI	*A	/81	(-)	Hawaii eliminated coverage of AFDC recipients between the ages of 18 and 21 years old.
IN	*P	1/82	(+)	The Indiana legislature reported that a bill had been introduced to provide eligibility to pregnant women whose expected children would be eligible if already born. Pregnant women would be eligible only for those Medicaid services of direct benefit to expected children (HB1119).
LA	*A	10/81	(+)	Louisiana revised its policies to provide AFDC eligibility for unborn children seven months after the pregnancy has been medically determined.
MN	*P	1/82	(+)	The Minnesota legislature reported the introduction of a bill to include children receiving foster care maintenance payments as Medicaid eligibles (HF1690).

MN	*A	/82	(+)	Minnesota instituted Medicaid coverage of women whose pregnancy has been medically verified and who would be eligible for AFDC if the child were born and living with the mother.
MS	*P	2/82	(+)	The Mississippi legislature reports the introduction of a bill to provide eligibility to pregnant women and foster care children (HB233).
MS	*A	1/82	(-)	Mississippi dropped coverage of the optional AFDC 18- to 21-year-old group.
NV	*P	3/82	(+)	Nevada proposed to extend Medicaid eligibility to pregnant AFDC women as soon as pregnancy is medically verified, even though an AFDC grant is not provided until the sixth month. Savings anticipated by reducing the risk of complicated pregnancies, high risk and/or defective newborns.
NJ	*P	2/82	(+)	The New Jersey legislature reports the introduction of bills to create a medically needy program (A693 and AB7).
NJ	*P	2/82	(+)	The New Jersey legislature reported the introduction of a resolution bill to study the feasibility of providing Medicaid eligibility to certain handicapped children (SCR82 & S1060).
NJ	*P	2/82	(+)	The New Jersey legislature reports the introduction of a bill to provide services to the medically needy (AB7).
NJ	*A	6/78	(+)	The State of New Jersey added coverage of pregnant women.
NC	*A	2/82	(-)	North Carolina eliminated coverage for 19- and 20-year-old AFDC recipients in the medically needy classification.
OR	*P	/82	(+)	The Oregon legislature expanded the definition of categorically needy to include persons required for inclusion under federal law and persons who may be included optionally subject to availability of federal funds (SB 889). However, the Medicaid Agency has not yet implemented it.
RI	*P	4/82	(-)	Rhode Island proposes to reduce the eligible age of a child to 18 (including foster children) unless the child is completing secondary school or training before his/her 19th birthday. This is in line with an effort to conform Medicaid to AFDC eligibility standards.
RI	*P	1/82	(+)	The Rhode Island legislature reports introduction of a bill to require that self-pay nursing home residents be permitted to remain in the nursing homes as a Medicaid recipient after depleting their funds (H7312).

SC	*A	1/82	(-)	South Carolina eliminated its general disability assistance group from Medicaid coverage. (This group, disabled individuals whose income was too high to meet SSI or SSA requirements, had been covered through state funds only.)
SC	*A	/81	(-)	South Carolina dropped Medicaid coverage of AFDC recipients between the ages of 18 and 21.
SC	*A	/80	(+)	South Carolina initiated Medicare "buy-in" coverage for its institutionalized clients receiving optional state supplementary payments.
UT	*A	/79	(-)	Utah eliminated the stepchild assistance program.
VA	*A	7/82	(-)	Virginia discontinued coverage of medically and categorically needy ADC recipients between the ages of 18 and 21 years.
VA	*A	7/82	(-)	Virginia discontinued coverage of recipients whose Medicaid eligibility was based upon Title XX child care payments.
VA	*A	7/82	(-)	Virginia discontinued coverage of medically needy caretaker relatives whose eligibility was based upon ADC (exceptions: prenatal and delivery services for pregnant women).
WA	*A	11/81	(+)	The Washington State legislature passed a law which provides eligibility to pregnant women (2SHB557).
WA	*A	7/81	(-)	Effective July 1, 1981 the State of Washington combined its medically needy and medically indigent programs into one program entitled the Limited Casualty Program (LCP). Not covered under this new program are: persons under 21 in foster care, subsidized adoptions, or institutions; pregnant women not qualifying for AFDC or SSI; two-parent families which fail to meet the non-financial standards for AFDC or SSI; or individuals who don't incur medical expenses equal to their excess income or resources as determined by the state's new regulations. Individuals are certified eligible for a maximum of three months. The LCP program is designed to provide limited scope medical care and covers only the following services: inpatient hospital services, OPD and rural health clinic services, physicians and clinic services, prescribed drugs, dentures, prosthetic devices, eyeglasses, SNF, ICF, and ICF-MR services, home health services, other lab and x-ray services, and medically necessary transportation. The services formerly covered under the state's medically needy program which are not covered under the LCP program are: EPSDT services, dental, chiropractic, outpatient physical therapy services except under home health care, and private duty nursing services.

For those eligible for the LCP program based on its medically needy criteria, a deductible not to exceed one-half of the cost of the first day of inpatient hospital care is applied to each hospital admission. In addition, a patient co-pay or deductible of $3.00 is applied to each emergency room visit.

For those qualifying for the LCP program under its medically indigent criteria, care is limited to treatment for acute and emergent conditions. A deductible of $1,500 for acute and emergent medical services per family in any twelve-month period is required. This is in addition to excess non-exempt income as defined by the state in its July 1, 1981 standards which must be applied to medical expenses.

B. Income Levels

AL	*P	1/82	(+)	The Alabama legislature reported the introduction of a bill to provide that persons eligible to receive cost of living increases from Teacher's Retirement not be given the adjustment in cases where it would make them ineligible for Medicaid (S84).
AL	*A	11/81	(+)	Updated state plan to show current information per change in ADC need standard and ADC-Foster Care payment.
AL	*A	10/81	(+)	Alabama increased the monthly income eligibility level for persons in nursing homes from $667 to the maximum federal benefit ratio limit of $794.10 (300% of SSI).
AL	*A	7/81	(+)	Increased the income levels under the optional state supplemental payment program.
AL	*A	5/81	(-)	Decreased the income levels under the optional state supplemental payment program.
CA	*P	7/82	(-)	California proposes to reduce the income standards for the Medically Needy, Optional Categorically Needy and California-only Medically Indigent categories to 100% of the AFDC Maintenance Need Standards.
CT	*P	2/82	(+)	The Connecticut legislature reports a bill to increase income eligibility levels to the federal maximum allowed (H5442).
CT	*A	7/81	(+)	Connecticut increased the medically needy income eligibility levels.
FL	*A	10/81	(+)	Florida increased the cost of care level from $286 to $297 for Level Two cases (Level One cases remained at $286) for aged, blind and disabled recipients in adult foster homes. (Level Two cases need assistance in performing the basic activities of daily living; Level One cases are more self-sufficient.) It also increased levels for individuals receiving room and board with personal care from $305 to $312. Personal needs allowance for both groups is $35.
FL	*A	7/81	(+)	Florida increased the income limitations from $647 to $720 per month for individuals in nursing homes, mental hospitals, TB hospitals, and ICF/MRs.
IL	*A	3/81	(+)	Illinois increased medically needy income standards.
MD	*P	7/82	(+)	Maryland proposes to increase the AFDC payment levels by 9%.

MD	*P	7/82	(+)	Maryland proposes to increase the medically needy income eligibility levels.
MI	*A	12/81	(-)	Michigan decreased medically needy income standards for three or more persons.
MI	*A	8/81	(+)	Michigan increased medically needy income standards for three or more persons.
MI	*A	7/81	( )	Michigan increased medically needy income standards for one and two persons; decreased standards for three or more.
MN	*A	/81	(+)	Minnesota increased its income standards for AFDC recipients.
NJ	*A	7/81	(+)	New Jersey increased the income eligibility standard for nursing home residents to $794.10 per month.
NM	*P	/82	(-)	New Mexico recently submitted a waiver request which would allow it to cease granting cost-of-living increases.
NM	*P	12/81	(-)	New Mexico plans to freeze its income standards for its institutionally needy program and has requested a federal waiver to allow it to grandfather in current recipients in this program who would otherwise become ineligible due to Social Security cost-of-living increases.
ND	*A	7/81	(+)	North Dakota increased medically needy income levels.
ND	*A	7/80	(+)	North Dakota increased medically needy income levels.
ND	*A	7/79	(+)	North Dakota increased medically needy income levels.
RI	*P	4/82	(-)	Rhode Island proposes reduction of the income limits for the medically needy to the levels that were in effect prior to July 1, 1981. They are currently $4600 for an individual and $5100 for a family of two; these would be reduced to $4400 and $4900, respectively.
TN	*A	7/81	(+)	Tennessee increased the income standards for its medically needy population.
UT	*A	/81	(+)	Utah ceased deeming the income of parents of institutionalized children after the first full month of institutionalization.
UT	*A	/81	(-)	Utah adopted a new policy regarding AFDC earned income levels: If in the first month an AFDC family receives earned income that is 150% greater than the grant, then they become ineligible for AFDC.
UT	*A	/81	(-)	Utah limited its thirty and one-third AFDC income disregard. It restricted it to continuous four-month earnings and limited levels to $75 full-time or $60 part-time.

C. Resource Standards/Rules

CA	*P	7/82	(-)	California is proposing to require parents to make their assets available to their 18-to 21-year-old children who are not living at home and cannot demonstrate financial independence. This would require that parents' income and property would be counted in determining Medi-Cal eligibility for such 18-to 21-year-olds.
CT	*P	2/82	(+)	The Connecticut legislature reports the introduction of a bill to increase asset levels from $850 to $1,500 for Medicaid eligibility purposes (H5230).
HI	*A	/81	(-)	For its medically needy group, Hawaii lowered from $3000 to $1500 the exempt value of a motor vehicle.
HI	*A	/81	(+)	Hawaii raised its homestead exemption for the medically needy from $25,000 to $40,000.
HI	*A	/81	(+)	Hawaii raised its exemption to the medically needy for non-income-producing property from $250 to $500.
IA	*A	4/82	(-)	Iowa implemented a transfer of assets prohibition. If a transfer is made within two years of application for Medicaid, eligibility is postponed for up to six years on a sliding scale depending upon the amount of the transfer.
MD	*P	3/82	(+)	The Maryland Senate reported the introduction of a resolution to require nursing homes to inform residents of the availability of the monthly personal allowance (SJR61).
MA	*P	1/82	(-)	The Massachusetts legislature reported that a bill had been introduced to tighten the state's transfer of assets limitations (H183).
MI	*P	/82	(-)	The Michigan legislature is considering a bill which would tighten transfer of assets regulations (HB 4326).
MI	*A	10/81	(-)	Michigan reduced its categorically needy resource standard.
NM	*A	9/81	(-)	New Mexico instituted a transfer of resources policy which considers the "countable value" of resources transferred for less than fair market value as being available for the purposes of Medicaid eligibility determinations. Countable value is the uncompensated value of the resource minus the first $5,000. If this countable value plus other non-exempt resources exceeds the state limit, the individual will be ineligible for a period of 24 months. In any case where the countable value exceeds $12,000, the individual will be ineligible for an additional 12 months for each $6,000 of countable value.
NC	*A	10/81	(-)	North Carolina added personal property to the list of assets covered by the transfer of assets law.

ND	*A	/81	(+)	North Dakota implemented a bill passed by its legislature which limits the consideration, in eligibility determinations, of the resources of a separated spouse (SB 2307).
ND	*A	/81	(+)	North Dakota implemented a bill passed by its legislature which excludes prepaid funeral contracts from consideration in eligibility determinations (HB 1571).
RI	*P	4/82	(-)	Rhode Island proposes adjusting the categorically needy resource limits to match those of the AFDC program ($1,000 per assistance unit) and revising their transfer of assets policy.
SD	*A	/81	(-)	South Dakota implemented a law passed by their legislature which tightened their transfer of assets regulations. If real property is transferred for less than the market value, the uncompensated value is considered a resource for twelve months for that property valued at $12,000 or less, and for 36 months for property valued at over $12,000.
TN	*P	2/82	(-)	The Tennessee legislature reported the introduction of a bill to tighten its transfer of assets limitations (SB2143).
TX	*A	3/81	(-)	Texas implemented a new transfer of assets policy for anyone applying for Medicaid after March 1, 1981. An SSI-related applicant who transfers resources to another person without receiving fair compensation will have the value of those resources counted in eligibility determination for up to two years from the date of transfer, the amount of time depending upon the value of the resources.
UT	*A	/81	(-)	Utah adopted SSI policy relative to real accountable property and liquid assets. It will include: contracts for deeds, life estates, income-producing property and joint checking and savings accounts.
VT	*A	/81	(-)	Vermont tightened its transfer of assets requirements. In the event that non-exempt assets are disposed of for less than market value and less than two years prior to application for Medicaid, eligibility is postponed for a specific time period, determined by a sliding scale related to total uncompensated value.
VA	*A	7/81	(-)	The State of Virginia has tightened its rules concerning Medicaid eligibility for individuals who have transferred assets in order to become eligible for Medicaid. An applicant for or recipient of Medicaid is ineligible if he transferred or otherwise disposed of his legal equitable interest in real or personal property for less than fair market value within two years of application for or receipt of Medicaid. Transfer of property precludes eligibility for two years from the date of the transfer if the uncompensated value of the property was $12,000 or less. If the uncompensated value was more than $12,000, an additional two months of ineligibility will be added for each $1,000 of additional uncompensated value. Five basic exceptions to this policy are:

1) When the transfer was not made with the intent of establishing or retaining eligibility for Medicaid or Supplemental Security Income. Any transfer shall be presumed to have been for the purpose of establishing or retaining eligibility unless the appli cant/recipient furnishes convincing evidence to establish that the transfer was exclusively for some other purpose.

2) Retention of the property would have no effect on eligibility unless the property is a residence of an individual in a nursing home for a temporary purpose.

3) When transfer of the property resulted in compensation to the applicant/recipient which approximated the equity of the property.

4) When payment has been made on the cost of medical care approximating the equity of the property.

5) When the property owner has been a victim of another person's actions who, for any reason, obtained the property without the applicant's/recipient's full understanding of the action.

WA	*A	11/81	(-)	The Washington State legislature adopted a bill which tightens the state's transfer of assets prohibitions (2SHB557).
WV	*P	2/82	(-)	The West Virginia legislature is considering a bill to tighten its transfer of asset restrictions (SB 367).
WV	*P	/82	(+)	West Virginia has requested a waiver in order to disregard pre-need burial contracts with a value of under $2000 for nursing home patients.

D. Definitions

AK	*A	2/82	(+)	The State of Alaska increased the personal needs allowance for institutionalized individuals from $35 to $70 per month.
CA	*P	3/82	(-)	The California legislature reported the introduction of a bill be terminate eligibility to persons who live outside the state for two consecutive months (AB280).
HI	*A	/81	(+)	Hawaii broadened its AFDC coverage to include families with unemployed parents of either sex, not just unemployed fathers.
KY	*P	/82	( )	Kentucky is proposing that in calculating an applicant's eligibility for Medicaid actual work-related expenses will not be deducted from the allowable income. Instead, a set monthly amount of $75 for full-time employment and $40 for part-time employment will be deducted. The allowable child-care deduction may not exceed $160 for full-time employees and $110 for part-time. Step-parents living in the home receive the same earned income deductions as stated above.
KY	*A	10/81	(-)	Kentucky replaced coverage of services designated to an "unborn child" with services to a pregnant woman. This change allows the income of parents living with pregnant minors to be used in determining eligibility for Medicaid.
RI	*P	4/82	( )	Rhode Island proposes to establish work expense deductions for categorically/medically needy families in accordance with those established for the AFDC program.
RI	*P	4/82	(+)	Rhode Island proposes to provide medical coverage for an eligible pregnant woman within the first five months of pregnancy after confirmation of pregnancy is made.
RI	*P	4/82	(-)	Rhode Island proposes to require deeming the resources and income from sponsors of aliens to aliens in determining eligibility for medical assistance.
RI	*A	11/79	(+)	Rhode Island modified personal needs allowances for institutionalized, medically needy individuals. Previous allowance was $25 for the aged, blind and disabled and AFDC children and adults; and $110 for those working in sheltered workshops for whom retention of earned income is therapeutic. The allowance is now $30 per month for all institutionalized individuals.
VA	*A	7/81	(+)	The State of Virginia increased its personal needs allowance for nursing home patients from $25 to $30.
VA	*A	7/81	(+)	The State of Virginia has amended its policies to allow Medicaid recipients who are patients in ICFs to retain a portion of their earnings in addition to the $30 personal needs allowance if they are involved in a vocational activity which is part of a planned habilitation program. Such a program must be carried out in a therapeutic work program, such as a sheltered workshop, or as part of organized vocational or prevocational training.

E. Other

AL	*P	1/82	(+)	The Alabama legislature reported the introduction of a bill to provide that persons eligible to receive cost of living increases from Teacher's Retirement not be given the adjustment in cases where it would make them ineligible for Medicaid (S84).
CA	*P	7/82	(-)	California proposes to eliminate three-month retroactive Medi-Cal eligibility for its state-only funded Medically Indigent Adult category.
KY	*A	12/81	(-)	Kentucky began denying benefits to a family for any month in which the caretaker is participating in a strike on the last day of that month.
MI	*P	1/82	(-)	The Michigan State legislature has introduced a bill which requires that a person must have resided in the state for at least six months in the last 12 months to be eligible for general assistance (HB 5160).
MS	*P	1/82	(-)	The Mississippi legislature reported the introduction of a bill to require that the Department of Public Welfare, Board of Health, and Medicaid Commission coordinate and monitor application procedures for public assistance programs (HB506).
VT	*P	1/82	( )	The Vermont legislature reported introduction of a bill to bring state laws concerning AFDC eligibility into compliance with the new federal law (H646).
VA	*A	7/81	(-)	The State of Virginia has revised the income scales it uses to compute the ability of a spouse at home to contribute to the support of his or her husband or wife in a nursing home. The state has a law which requires that an individual support his or her needy spouse and that a parent be responsible for support of his or her children to age 18. The revised scale is based on national poverty levels which are higher than previously used Medicaid income scales.

Alternative Methods of Service Delivery/Program Management

VI. Alternative Methods of Service Delivery/Program Management

A. Capitation

CO	*A/W	3/82	(-)	Colorado applied for a freedom of choice waiver to require Medicaid recipients in Mesa County to obtain health care services from providers associated with the Rocky Mountain Health Maintenance Organization. A two-year waiver was granted by HCFA on March 3, 1982.
CT	*P/W	3/82	(-)	Connecticut applied for a freedom of choice waiver to impose a copayment on medical transportation (taxi and livery) and to exempt frequent users of such transportation. The waiver request was disapproved by HCFA on March 2, 1982.
GA	*C	/82	(-)	Georgia is considering contracting with HMO's for medical services.
HI	*C	7/82	(-)	Hawaii is considering physician reimbursement by capitation, through HMOs, rather than by fee-for-service. (Projected savings: $30 million. In addition, there is a projected savings of $2 million in fiscal intermediary costs, if this is proposal implemented.) An alternate method of reducing physician costs, also being considered, is the adoption of the CPT-4 procedural code system, with fixed dollar amounts for each procedure.
HI	*P	2/82	(-)	The Hawaii legislature reported introduction of a bill to establish an HMO demonstration project (HB2906-82).
MA	*A	9/81	(-)	The State of Massachusetts has developed a new Managed Health Care program which incorporates the present case management program (a fee-for-service project in which primary care providers must authorize all services) and the present health maintenance organization program (a capitation project) along with a new initiative to develop capitated fiscal intermediaries who subcontract for the provision of health services.
MA	*D	/81	(-)	The State of Massachusetts has been granted waivers for a project to ascertain the impact of alternative forms of health insurance on the utilization of medical care and any resultant effects on the health status of individuals.
MA	*D	1/80	( )	The State of Massachusetts has received waivers to assist the Boston City Hospital in the development of a capitated reimbursement system for the hospital and its community health centers to serve an enrolled population of city employees, Medicaid recipients, and those who have no form of health insurance.
MI	*P/W	/82	(-)	Michigan applied for a freedom of choice waiver which would allow the state to "lock-in" a Medicaid recipient to an HMO for a 5-month period after his first month of enrollment.

MI	*P/W	/82	(-)	Michigan applied for a freedom of choice waiver to establish a primary care physician sponsor program to be pilot-tested in Wayne County and later statewide. A Medicaid recipient would select a participating physician sponsor who would provide primary care and who would authorize any other necessary non-emergency medical services. Physician sponsors would receive the usual fee for service plus a case management fee for each recipient. The waiver was approved by HCFA on February 9, 1982 for a two-year period.
MI	*P/W	/82	(-)	Michigan has applied for a freedom of choice waiver to implement a capitated ambulatory program. Clinics or groups of physicians offering primary care and comprehensive health services will be reimbursed on a negotiated capitation risk basis (minus HMOs).
MI	*A	/81	(-)	The Michigan Department of Social Services is assuming a more active role in marketing HMO's to Medicaid recipients.
MN	*P	2/82	(-)	The Minnesota legislature reports that a bill has been introduced to establish a primary care case management system (SF2044).
MO	*A	1/82	(-)	Missouri implemented a prepaid health care program for St. Louis City general relief recipients.
NV	*C/D	/82	(-)	Nevada is considering a pilot project involving capitation payments to LTC facilities for all physician services provided to LTC patients.
NJ	*D	4/81	(-)	New Jersey proposed a demonstration of a physicians' case management system which was disapproved by HCFA. The state plans to resubmit the proposal, which would cover two counties.
NY	*P/W	/82	(-)	New York has requested a freedom of choice waiver to require that new Medicaid enrollees in a federally-qualified or State-certified HMO not be permitted to disenroll without good cause during the five-month period following the first month of enrollment. Enrollees may disenroll for any reason during the first 30 days following the effective date of enrollment.
NY	*D	9/80	(+)	The Metropolitan Comprehensive Care Program has as its key components the provision of improved access and continuity of care through the implementation of "Citycaid." The program will provide health care coverage to a maximum of 17,100 medically indigent and will develop a comprehensive case management system at Metropolitan Hospital. Ultimately it will become an HMO. Funding is 50% federal, 50% local.
OH	*C	/82	(-)	Ohio is considering expanded use of HMOs.
PA	*P/W	/82	(-)	Pennsylvania has requested a freedom of choice waiver in order to identify and assign "overutilizers" to a physician who would be solely responsible for their care.

UT	*P/W	/82	(-)	Utah has requested a freedom of choice waiver in order to limit recipients to one of three alternatives for primary care: (1) HMO Utah, a prepaid non-certified health delivery system sponsored by BC/BS of Utah; (2) Family Health Program, a certified HMO delivery system reimbursed by a contractual prepaid arrangement; or (3) a primary care physician on a fee-for-service basis.
WA	*P	7/82	(-)	The State of Washington is pursuing capitation reimbursement alternatives for prescriptions provided to nursing home patients.
WA	*P/W	/82	(-)	Washington requested a freedom of choice waiver seeking to implement a $5.00 copayment for emergency hospital and outpatient hospital visits for all Medicaid recipients, except residents of institutions. HCFA disapproved this request, stating that the legislative provision referenced provided no authority to approve waivers for copayments.
WA	*P/W	/82	(-)	Washington submitted three requests for freedom of choice waivers to waive certain Medicaid regulations concerning UC/UR activities in nursing homes. These requests were disapproved by HCFA.
WI	*P	2/82	(-)	Wisconsin has requested a federal waiver to encourage provider/recipient risk-sharing through a phased-in lock-in provision that offers at least one HMO or prepayment option to all Medicaid recipients. The costs are expected to be at or below the current statewide average per capita expenditure and thus lower overall. All qualified providers will have an opportunity to compete. (Estimated annual savings: $20 million.)

B. Long-Term Care Delivery

CA	*P/W	/82	(-)	California requested two section 2176 home- and community-based LTC services waivers. The first sought to provider personal care services, case management, homemaker and related services to the aged, blind and disabled needy recipients receiving SSI/SSP payments. The second waiver request was designed to provide respite care, homemaker and home health services, adult day training, personal support and habilitation services, transportation, and regional center direct client support services to handicapped, developmentally disabled individuals. HCFA disapproved both waiver requests on March 18, 1982 stating that they did not meet the statutory and regulatory requirements necessary to obtain the waivers.
CA	*A	7/81	(+)	California has implemented the Multipurpose Senior Services Project designed to evaluate the effects of providing, through a single program source, a comprehensive array of social and health services needed by persons 65 years of age or older who are immediately "at risk" of long-term institutionalization.
CT	*P	2/82	(-)	The Connecticut legislature reports the introduction of a bill to require that the state apply for home and community-based LTC services waivers (H5265).
DC	*P	9/82	(-)	The District of Columbia is planning to apply for a waiver for a home and community-based long term care project.
DC	*A	9/81	(+)	The District of Columbia received an 1115 waiver of statewideness in amount, duration and scope to provide services to 59 deinstitutionalized, chronically mentally ill recipients. Services provided include: case management, crisis intervention, crisis stabilization, individual life-skill training, and individual counseling.
FL	*P/W	/82	(-)	Florida has requested two section 2176 home- and community-based LTC service waivers to provide case management, adult day health, and respite care services to the mentally retarded, aged, and disabled beneficiaries, and homemaker and personal care services to the mentally retarded.
FL	*P	/82	(-)	Florida submitted a waiver for approval by HHS to provide Medical Adult Day Health Care for SSI recipients over 18 years of age who are in danger of institutionalization or who are inappropriately placed in a long term care facility.
GA	*P	/82	(-)	The Georgia legislature is considering a bill which would encourage home- and community-based long term care alternatives to institutionalization for the elderly who are physically or otherwise impaired (SB581). The are also considering a companion bill which would require the Department of Human Resources to set up a pre-admission screening program (HB1606).

GA	*P/W	/82	(-)	Georgia has requested a section 2176 home- and community-based LTC service waiver to provide home health aide, personal care, physical, occupational, and speech therapy services to aged, disabled, and mentally retarded beneficiaries.
HI	*P	/82	(-)	Hawaii is planning on applying for a waiver, under the Omnibus Budget Reconciliation Act of 1981, for home and community-based care. The project would be limited to Oahu Island, and would provide alternative care for mentally retarded recipients who are presently institutionalized. Services would include day care, respite care, personal care and the regular range of Medicaid services.
IN	*A	7/82	( )	The Indiana legislature reports that a bill has been passed to require the Department of Public Welfare to request a waiver for the provision and reimbursement of respite care services under the Medicaid program. In addition, the state would develop a respite care program for developmentally disabled and mentally ill individuals who are not eligible for Medicaid (HB1202).
IN	*P	1/82	(-)	The Indiana legislature reported that a bill had been introduced to establish a mandatory nursing home preadmission screening program for all persons entering long term care facility (SB299).
IA	*P/W	/82	(-)	Iowa has requested a section 2176 home- and community-based LTC service waiver to provide assessment and case management services to individuals who would otherwise require institutional care. Initial implementation will involve Scott County.
KS	*A/W	3/82	(-)	Kansas requested a section 2176 home- and community-based LTC services waiver to provide case management, homemaker services, personal care services, home health aide services, adult day health services, habilitation services, respite care and hospice care to elderly and disabled persons who would otherwise require institutional care. HCFA approved this request on March 22, 1982 for a period of three years.
KS	*P/W	/82	(-)	Kansas has requested a section 2176 home- and community-based LTC service waiver to provide occupational, physical and speech therapy to individuals currently residing in adult care homes within five Kansas counties.
KS	*P/W	/82	(-)	Kansas requested a section 2176 home- and community-based LTC services waiver to establish two levels of intermediate care within the State plan: One for those individuals who receive a great deal of nursing services, and one level for those individuals who do not require a high degree of nursing services. HCFA disapproved this request on March 18, 1982, stating that it did not fall within the purview of the legislation authorizing such waivers.

KY	*P	2/82	(-)	The Kentucky legislature has reported the introduction of a bill to provide those services needed to prevent unnecessary institutionalization and to apply for waivers where required (H674).
KY	*P	1/82	(-)	The Kentucky legislature reported that a bill had been introduced to create a fund to receive contributions to Medicaid. The bill also gives state income tax deductions to fund contributors and to those caring for the elderly in the home (S36).
LA	*A/W	1/82	(-)	Louisiana requested a section 2176 home- and community-based LTC services waiver to provide homemaker, adult day health, and habilitative services to aged, disabled, and mentally retarded beneficiaries. This request was approved by HCFA on January 6, 1982 for a period of three years.
MA	*P	2/82	( )	The Massachusetts legislature reports that a bill has been introduced to provide a $3000 tax exemption for care of the elderly at home (S1329).
MA	*P	2/82	(+)	The Massachusetts legislature reported that a bill has been introduced to continue Medicaid coverage to disabled persons for homemaker services (H988).
MA	*P	1/82	( )	The Massachusetts legislature reported that a resolution has been introduced directing the state to apply for waiver under Section 2176 of PL 97-35 (community-based LTC programs) for Adult Foster Care and Respite Care (S634).
MI	*C	10/82	(-)	The State of Michigan intends to file a waiver under Section 2176 of PL 97-35 for community-based LTC. Various delivery models and reimbursement methodologies will be considered. Research is underway with particular emphasis on cost and utilization controls.
MN	*P	2/82	(-)	The Minnesota legislature reported that a bill has been introduced to allow state tax credits for care of the elderly in the home (HF1861).
MN	*P/W	/82	(-)	Minnesota has requested a section 2176 home- and community-based LTC service waiver to provide case management, homemaker, home health aide, personal care, adult day health, and respite care services to aged and disabled beneficiaries.
MN	*D	/81	(-)	Minnesota initiated a preadmission screening program for Medicaid recipients seeking admission to SNFs and ICFs. Alternative community care, if no more costly, is offered as an option. A waiver is being applied for regarding home- and community-based services.
MS	*P	1/82	( )	The Mississippi legislature reported the introduction of a bill to require nursing homes to participate in Medicare (SB 2589).

MS	*A	7/80	(-)	Mississippi placed a cap of 100 on the number of nursing home beds per 1,000 Medicaid recipients for which they would provide reimbursement. The resulting total number of beds was then allocated among individual facilities. The cap was in effect for one year, but in July of 1981 the federal government asked them to cease. Mississippi has appealed the ruling, and a hearing will be held in April, 1982.
MS	*A	7/79	(-)	Mississippi initiated a two-year moratorium on issuance of Certificates of Need (CON) for construction of new nursing home beds. The Senate has passed a bill (427), and House passage seems likely, which would continue the moratorium for two more years.
MO	*P	1/82	(+)	The Missouri legislature reported the introduction of a bill to provide hospice services.
MO	*P/W	/82	(-)	Missouri has requested a section 2176 home- and community-based LTC service waiver to provide homemaker/chore, adult day treatment, respite care, and adult family home services to aged beneficiaries.
MT	*A/W	12/81	(-)	Montana applied for a section 2176 home- and community-based LTC services waiver to provide case management, homemaker, adult day health, habilitative, respite care, nursing, psychological, occupational, speech, and physical therapy services to mentally retarded beneficiaries. HCFA approved this request on February 2, 1982 for a three-year period, effective December 2, 1981.
NV	*C/D	/82	(-)	Nevada is considering a pilot project involving capitation payments to LTC facilities for all physician services provided to LTC patients.
NV	*C/D	/82	(-)	Nevada is considering a demonstration project to provide a capitation payment to LTC facilities for prescription drugs provided to LTC patients.
NV	*P/W	/82	(-)	Nevada has requested a section 2176 home- and community-based LTC service waiver to provide case management and habilitation services to mentally retarded beneficiaries.
NJ	*D	5/82	(+)	New Jersey proposes to conduct a demonstration project to provide service reimbursement for former psychiatric hospital patients in Housing and Urban Development-sponsored community housing.
NJ	*A	/81	(-)	New Jersey is participating in a long term care channeling project.
NJ	*D	5/82	(+)	New Jersey proposes to conduct a demonstration project to provide service reimbursement for former psychiatric hospital patients in Housing and Urban Development-sponsored community housing.
NY	*P	1/82	(-)	The New York legislature reported the introduction of a bill to require the State to apply for a home and community-based services waiver under Section 2176 of P.L. 97-35 (S7742 and A9589).

ND	*P	6/82	(-)	North Dakota plans to submit to HCFA one or more applications for 1915(c) waivers for home and community-based LTC case management. They plan a phased approach, beginning with the developmentally disabled and mentally retarded and following later with the aged and the disabled.
OH	*D	/78	(-)	Ohio completed in December, 1981 a three-year demonstration project designed to evaluate alternatives to nursing home care. Home and community-based services were explored, as well as different levels of nursing home care.
OR	*P	1/82	(-)	The Oregon legislature reports that a bill has been introduced to impose a one-year moratorium on nursing home bed expansion by denying CON in areas where the ratio of beds to elderly would exceed 40 per 1000. (SB975XX)
OR	*P	1/82	(-)	The Oregon legislature reports that a bill has been introduced to provide state tax credits to care for the elderly at home (HB2485).
OR	*A/W	12/81	(-)	Oregon requested a section 2176 home- and community-based LTC services waiver to provide homemaker services; non-medical transportation; substitute living services; residential care facility services to aged, disabled, and mentally retarded beneficiaries; and case management, habilitative, and respite care services to mentally retarded beneficiaries. HCFA approved this request on December 23, 1981 for a period of three years.
RI	*P/W	/82	(-)	Rhode Island has applied for a section 2176 home- and community-based LTC waiver to provide alternatives to institutional care for the chronically impaired elderly. This would be a pilot project involving two hospitals. As of April 1982, patients who qualify for a nursing home would be assessed for the alternative program, which includes home health agency visits, durable medical equipment where appropriate, case management, day care and/or homemaker services. The cost of provision of these services could be no higher than the cost of nursing home care would be. Future waiver applications may seek to extend this program to the mentally retarded and the mentally ill.
SC	*D	1/82	(-)	South Carolina has received a waiver, under Section 966 of Public Law 96-499 (the Omnibus Reconciliation Act of 1980), which will allow them to establish a Homemaker/Home Health Aide Project in four counties. The project will be funded at 90 percent by HCFA, and will last for five years, including six-month start-up and close-out periods. The state agency will train and employ (through a subcontract) twenty-five AFDC recipients in each county to care for the elderly, handicapped and disabled so that they may remain in their homes and avoid institutionalization. The service will be available without regard to income, and a reasonable amount will be charged on a sliding scale basis for services provided to individuals who have income in excess of 200 percent of the state needs

standards. South Carolina plans to apply for a waiver of 42 CFR, Subpart B, 435.1007 in order to do this. Other waivers needed would allow them to continue Medicaid coverage for 12 months for eligible participants employed under this project (42 CFR, Subpart B, 435.112), and to substitute personal care services for other services provided for in the plan (42 CFR, Subpart B, 440.210 and 440.230).

SC	*D	/78	(-)	South Carolina's General Assembly established the Community Long Term Care Project (CTCP) in 1978, and HCFA approved an 1115 waiver for the project. This demonstration covers the disabled and elderly in three counties, providing such community-based services as medical day care, personal care, respite care, home-delivered meals, medical social services, expanded therapies and mental health counseling. Cost per individual must not exceed 75 percent of the cost of comparable institutional care. There is a proposal to expand the project statewide in July, 1982. The experimental phase will end July, 1983, with an evaluation to follow.
SD	*P	1/82	(-)	The South Dakota legislature reports that a bill has been introduced to impose a two-year CON moratorium on nursing home bed expansion (SB 38).
SD	*P/W	/82	(-)	South Dakota has requested a section 2176 home- and community-based LTC service waiver to provide non-institutional services to developmentally disabled beneficiaries.
TN	*P/W	/82	(-)	Tennessee has requested a section 2176 home- and community-based LTC services waiver to provide home health aide services to aged and disabled beneficiaries.
VT	*P	1/82	( )	The Vermont legislature reported that a bill had been introduced to give a $500 tax credit to families to care at home for the elderly, mentally retarded, or handicapped (H 675).
VT	*P/W	/82	(-)	Vermont has requested a section 2176 home- and community-based LTC services waiver to provide family education and training, respite care, service coordination, client support services, day activity, intensive day programs, and residentially-based habilitation and treatment services to mentally retarded and mentally ill beneficiaries.
VA	*P	2/82	(-)	The Virginia legislature reports the introduction of a bill to extend a CON moratorium on nursing homes until June 30, 1983 (HB879).

C. Other

NJ	*D	5/82	(+)	New Jersey proposes to conduct a demonstration project to provide service reimbursement for former psychiatric hospital patients in Housing and Urban Development-sponsored community housing.
NY	*D	/81	(+)	New York implemented a demonstration project in Suffolk County whose purpose is to demonstrate various physician reimbursement mechanisms including physician lock-in, case management, and fee-for-service, and to compare the various methods of reimbursement in terms of efficiency and cost-effectiveness.
WI	*P	2/82	(-)	Wisconsin has requested a federal waiver to allow its county mental health boards to act as case-managers and prudent purchasers of inpatient and outpatient mental hygiene services. (Estimated annual cost savings: $1 million.)

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